Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Edna Month P. Baker Juaust 2010 2100 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Solisbury Rehabilitation & Nursing Ctr. Jalisbur Dicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Min Days Hours 214-14-4106 1 □ M 2 🔀 F 84 04/03/1926 <u>Maryland</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 Edgemont Ave. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: white 3₺ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper retail grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Parsons Albert Twilley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Baker/son 1603 Winthrop Place, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 100 disease or condition resulting in death) 21 Due to (or as a consequence of): year. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury r as a consequence of): that initiated events 2000m resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 -N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 A Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Date signed (Month, Day, Year)

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

δ

Completed

Be

၉

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

2 ☐ Accident 3 Suicide

4 Homicide

29a. Certifier

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Wedical Evontment by notified a once.

Physician

Medical

sicien and burial-transit

physicien use as the ettending p for use as

signed by the e

examiner

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

rthis certificate has been s ral director, page 2 should To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

William H.

6 □ Could not be

determined

Robins, M.D. 200 32. Degistrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 720M 2010 0.5William Jiles Bowen August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 810 W. Isabella Street
5. Social Security Number 6. Sex Salisbury <u>Wicomico</u> If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Months Days 1**X** M 2□ F Pennsylvania 79 May 13, 1931 200-24-6758 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 XYes 2 No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 810 W. Isabella Street 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XIYes 2 No. 48-1952 If Yes, Give 1948-1952 Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: Black 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Repair orthopedic specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Giles Willie Lee unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Lee/brother 304 Glen Ave., Apt A1, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore V.A. Cem08/12/2010 Hurlock, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD f Funeral Service Licensee 21801 <u>JOLLEY MEMORIAL CHAPEL</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final AJCUO 2 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

salutry

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be ပ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "notical Examinations to notified at

filed within 7 II Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III

72 hours after death with

Maryland 21215-0036

altimore,

Examiner sician and burial-trans attending physician for use as the buria signed by the a cate has been si page 2 should to

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician/Medical 2 Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To Medical

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of

3 Suicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0.0 OME Na 31. Date filed (Month, Day, Year

6 ☐ Could not be

Registrar's Signature AUG 1 2 2010

and manner stated.

100 Ecarroll St.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 tate of Maryland / Department of Health and Mental Hygiene Reg. No. 127/2010dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ **Bridges** Thelma Jean 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 □ € [™]Dec°8,°°1930 229-64-1076 79 Director Usual Residence of Decedent 10b. County 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at **Funeral Director** MD Allegany Cumberland 1 Xes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a 214 Seymour Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white Completed 3 XVidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Gilbert Oatie (Surber) Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt.3 Box 380 Ridgeley WV 26753 **David Bridges** son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Rocky Gap Veterans Cemetery 8/11/201 **Flintstone** MD 4 Donation 5 Other (Specify) 21. Siznatur of Funeral Servi 22. Name and Address of Fulfieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical **Examiner** Securatelly ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 | No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Severe COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy death? 2 🗌 No 1 🗌 Yes Yes To the Funeral Director; After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 🗆 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLOWBROOK RD. STE. 470 CLIMBERLAND, MD 21502 2502 i

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 27

2010

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 Rose C. Czarnecki August 9, 8:25 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital blney Montgomery Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 🗆 M 2 🖳 F 087-24-9190 Hours Min. Sept. 28, 83 1926 Director Italy Usual Residence of Decedent 28a-f shov items 23a or 28a-1 snover must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13609 North Gate Drive 20906 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 231☐ No Black, White, etc. Ď 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 ☐XNo Specify. 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other Sales Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked of r other traumatic ever 2 Giuseppe Ciccone Frances Pillari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar R. Czarnecki/Husband 13609 North Gate Drive, Silver Spring , MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or ò Aug. 2010 Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts.) Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day been signed by the a should be detached t g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Congestive Heart Failure, Respiratory Failure (Chronic) Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of Diabetes Mellitus 24a. Was an s certificate has be lirector, page 2 s death? 1 Yes 2 No Yes 2 x No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Acciden Hospital or Attending 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signat 29c, License number 29d. Date signed (Month, Day, Year) D20367 August 11, 2010

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

1396 Piccar Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Kalman, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Daniel Charles Crone Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours Min. July 23, 1949 ^cMaryland 61 Director 214-54-0738 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21609 Kelso Drive 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural" 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Ray Crone Betty Jane Schildtknecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Crone-Wife 21609 Kelso Drive Hagerstown, 21742 Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory | Aug.17,2010| Hagerstown, Maryland 21. Signature of Funeral Se Osborne Tune Fally Home, P.A. Conococheague St. Williamsport, MD 21795 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner VIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events equence of): burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the the attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for 1 in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death be detached 9 Unknown P.O. I ģ Part II. **Other significant conditions** contributing to death but n<u>o</u>t resulting <u>in</u> the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? signed ! þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa ure and 29c. License numbe 29d. Date signed (Month, Day, Year)

3H-6

State Registrar 30. Name and address of person.

31. Date filed (Month

AMOUS

32. Registrar's

L.Dwight

			8, 8/16/10 home, CCD		se Type or Pri					re All Copie and Mental F			e.	
Por z			For State Registrar	,	State of W	aryland	_	rtificate of		ina ivientai i		201	0 270	06
			Decedent's Name	(First, Middle	e, Last)					2. Date of	Death		3. Time	of Death
F	Physicia Medic/	_	Melvin 1	Edmon	dson					Month 8/8	/20		013	3 ^M
<u> </u>	Examin				n, give street and number Medical C		r	4b. City, Town, C		f Death		ac. County of	Death Arundel	
	uneral		5. Social Security Nu 579-52-9		6. Sex 7. A	ge (In yrs. la	ast birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Date of (Month)	Birth Day Yea	942). Birthplace (State Country)	
	irector	ŀ	Usual Residence of I							7/1	.5 / 1 -	772	ND	
rylano	how			10b. County		10c. City	, Town or Lo						10d. Inside	-
ы Ма	8a-f s	ecto	MD		Arundel		Sn	adyside			10-	Citizen of Wh		es 2∐No
with t	a or 2	Funeral Director	10e. Street and Num 1543 Li		n Poad			10f. Zip Code 2076	. 1		Tog.	USA	at Country:	
eath	ns 23 must	era	11. Marital Status	LIICOII	12. Was Deceden	t Ever in U.S	3. 13.			gin? (Specify Yes or , Puerto Rican, etc.)	No-		American Indian,	
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	Department or result and wenter hygens. The mode is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Examinat must be notified at once.	þ	1 Never Marrie		Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	No		If Yes, specify Cub 1 □ Yes 2 □ No		, Puerto Rican, etc.)		Specify:	White, etc. Blac	k
5-6	"natu	letec	(Specia	15. Deceden	t's Education st grade completed)		(Give	dent's Usual Occu kind of work done	durina most	of working	16b.	. Kind of Busi	ness/Industry	
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Baltimore,	ortani injury e.		4 ☐ Donation :			MD		rans Ce 2. Name and Addr		Briscoe				
De rad	lmpol any ir		KIMAN	HILLI	MUNDO	2.10M				nington				
	⁄sician ledical		23a. Par 1. Enter the strok, or hear Immediate Cause (fisease or condition resulting in death)	Final	complications that cause only one cause on each a. Due to (or a	40Ca	rdes	ter the mode of dy	ing, such as	rdiac or respirato	ry arrest,		Approxin Interval I Onset ar	nate Between nd Death
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pe	ısit	nine	Sequentially list con if any, leading to imreause. Enter United Cause (Disease or i	IVRIG	Due to (or a	s a consequ	ience of):							
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6876 tificate be	physic the b	dica			d									
O. Box 6	r the attending physician and ched for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of d	Ideath 3	☐ Ectopic pregnar ☐ Other (specify)	псу			23d. Date Mon	of delivery th Day	Year
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Division I or Attending	Direct Direct	ertifi	3 ☐ Suicide 4 ☐ Homicide	detern	nined 28e. Place of I building,	njury - At ho etc. <i>(Specif</i>	ome, farm, st y)	reet, factory, office	•	28f. Locati City o	on <i>(Stree</i> r <i>Town,</i> S	t and Numbe itate)	r or Rural Route I	lumber,
e Hospita	within 24 routs aren dearn. To the Funeral Director: Af completely filled in by the fur	Medical Certification: To			ng Physician: To the bes Examiner: On the basis and manner	of examina								se(s)
To th	To th	Me	29b. Signatule and	title of certific	er			29c. Licer	nse number		29d.	Date/signed	(Month, Day, Yea	r)
	M6+1		149	AKD	More No)		- DI	637	16		8/15	10	
Bh	tial		30 Name and 10 re	ess of persor	who completed cause o	death (Item	23a) (Type	Par Dew	ay, k	maou	lis.	CM	21401	,
	Sta Registr		31. Date filed (Mont	th, Day, Year,	010 January	strar's Signa	ture	w	0, ,	0	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G906, 8/27/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aug -2010 2:30 P M WILMA IRENE FITZWATER 6, Medical 4a. Facility Name (if not institution, give street and number)
Allegany Health Nursing & Rehab 4c. County of Death
Allegany 4b. City, Town, or Location of Death Examiner Cumber land 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Aug - 19,1921 215-18-8865 Months Hours 1 M 2 E F West Virginia Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Cumberland **Allegany** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 730 Furnace Street 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ Black, White, etc. 1 X Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker Government is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nannie Riffey Israel Fitzwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traignee. 25434 Paw Paw, WV Freda Kerns - Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗖 Burial 2 🗆 Cremation 3 🗖 Removal from State Rest Haven Memorial 8-10-2010 Harrisonburg, VA 4 Donation 5 Other (Specify) Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kimble Funeral Home Paw Paw, WV 25434 188 Moser Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anna Sweet Immediate Cause (Final Physician/ Covona disease or condition TOOK Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate touch. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an n. After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No Hospital Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No s after death.

I Director: Af
d in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00033280 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta 625 Kent Ave. Ste.101 Cumberland, MD 21502 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°10 Barbara Louise Fritz 4:25 p. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death St. Mary's St. Mary's Nursing Center Leonardtown Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 10, 1 □ M 2 🖵 F Months Days Hours Min. 372-30-5776 78 1931 Michigan Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 29191 All Faith Church Road 20659 United States or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary U.S. Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Conroy Ardean Scheel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29191 All Faith Church Rd., Mechanicsville, 20659 Mira Barks/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Sept. ö 1 KBurial 2 Cremation 3 Removal from State Arlington National Cem. injury 4 Pongtion 5 Other (Specify) 2010 Arlington, VA 21. Sig f Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P. 30195 Three Notch Rd., Charlottte ₩M00817 MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl, shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Dea Immediate Cause (Final Physician, disease or condition monda Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequen burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical requires that the death certificate be as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months?

1 Yes 2 No Month Pregnant at time of death been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has page 2 autopsy performe certificate 1 Yes 2 No 1 🗌 Yes 2 🖺 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Matural Natural 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifaing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cau

31. Date filed (Month

James Jarbøe, MD, 2403/5

AUG 19 2010

Three Notch Rd., Hollywood, MD 20636

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical August 12, 2010 Angelina Goffredo 10:10 a 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Retheada Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 F Months July 16, 1916 219-36-7836 West Virginia 94 Director Usual Residence of Decedent 10a. State 10b. County ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Maryland Mon topomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5304 Flanders Avenue 20895 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2 XNo 1 Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Teacher Elementary Education Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Goffredo Vittoria Iafolla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Lucy G. Humphreys/Sister 5304 Flanders Avenue, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 k Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) August 16 Gate of Heaven Cemetery 2010 Silver Spring, Maryland 21. Signature rel Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Aortic Stenosis Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence on). resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical

that the death certificate be by the signed t or Attending Physician: The law requires nas Certificate: within 24 hours a To the Funeral C To the Hospital

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other

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within 72 hours after death

Baltimore, Maryland 21215-0036

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Records,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check only	y one)
examiner? 1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exan	sician: To the best of my knowledge, death occured at the time, date and place, and du iner: On the basis of examination and/or investigation, in my opinion, death occurred at the insertion part to the basis of examination and/or investigation.	time, date and place, and due to the cause(s) and manner stated

29c. License number

D65720

Georgetown Road, Bethesda, MD 20814

29d. Date signed (Month, Day, Year)

August 12, 2010

DHMH 17 Rev 7/2009

State Registrar 29b. Sigra

ure and title of certifie

and address of pers Rosemary C.

31. Date filed (Month, Day, Year)

Intumbe, MD 8600 01

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7		Kharı 4a. Facility Name (if not institution	rim St. Thor	pio				August	7, 201	Year 0	1320 hrs
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212 ould be Mental marke ic event	8	Leslie Gayle					Shane	Murrav			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Shane Grant/ Mo 20a. Method of Disposition	ther	I ook I	3240	Park M	lills Roa	d, Adams	town	n, Maryl	and 21710
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ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be eath. The this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the buritation: To Be Completed by Physician Model.		Bb. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregn	ancy 2 Fetal	death 3	Ectopic pregr	ancy		Date of delivery	
ath ce ath ce or use	<u>.</u>		4 Pregnant at tii	me of dea	ith	(Specify)	coopic pregi	iaricy	[]	Month Da	ay Year
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of Vital Records, ng Physician: The law require ther this certificate has been signeral director, page 2 should by 11. To Be Completed	2							24a. Was autor		24b. Were auto	opsy findings available impletion of cause of
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ital Reisician: The scerificate rector, page		5. Was case referred to medical examiner?				26.Plac	ce of Death (Check		2 🗸 No	1 Yes	2 No
Physic Physic or this cral dire	Ĺ	1 Yes 2 No	Hospital: 1 / Inpatient	2 🔲 E	R/Outpatient 3		Othor: 5		Residen	ice 6 Other:	
In of ding Pt		7. Manner of Death	28a. Date of Injury (Month, Day, Year Aug 3, 2010) 2	28b. Time of Injur	/ 28c. Inj	ury at Work?	28d. Describe	how injur		
sion trend death death ctor: y the		Natural 5 Pending Accident Investiga		´ '	0000 hrs	1_	Yes 2 🗸 No	Subject sho	t self		
Division o papital or Attending hours after death. neral Director: After filled in by the fune Certification:		Suicide 6 Could no	ot be 28e. Place of Injur	y - At hon	ne, farm, street, fa	ctory, office	building, etc.	28f. Location (S	Street and	d Number or Rura	al Route Number, City
Spital hours hours filled		Tremidao	(Specify) Singl	e Fami	ly			i orlown S	tate)	l, Adamstown, N	
		Pa. Certifier 1 Certifying Physical Examination	cian: To the best of my k	nowledge	, death occurred	at the time, o	late and place, and	due to the caus	e(s) and	manner as stated	
To the H within 24 To the Ft completed	تا	2 Wiedical Examini	er: On the basis of examin and manner stated.	ation and	/or investigation,	in my opinio	n, death occurred a	at the time, date	and place	e, and due to the	cause(s)
Σ	29	b. Signature and title of certifier				29c. Licen:	se number		29d. Da	ate signed (Month	n, Day, Year)
		· 11100	(M)			0.C.	M.E.		Augu	st 10, 2010	
	30	. Name and address of person who									
2	L	Russell Alexander MD.	Assistant Medical			nn Street	, Baltimore, M	D 21201			Î
State Registrar	31	Date filed (Month, Gay, Year)	32. Registrar's		. Bar	1					
registral	4_			100	19000						

10-06059 Brian Andre Grant		lelible Ink. Ensure All Copies Are Le tment of Health and Mental Hygiene	
Sharr mare Grant		ificate of Death	2010 27011 Reg. No.
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)	2. Date of Dec Month August 12	Day Year
	4a. Facility Name (if not institution, give street and number) 1000 Mercy Avenue	4b. City, Town, or Location of Death Oxon Hill	4c. County of Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24Hrs. 8. Date of B	irth(MM/DD/YYYY 9. Birthplace (State or
Director	578–19–0346 1∑M 2□F 21	Yrs. Months Days Hours Min. May	10, 1989 Foreign Washington
ıny	Usual Residence of Decedent 10a. State 10b. County 10c. City, T.	own or Location	10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Importants. If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Wash	ington D.C.	1 X Yes 2 No
the Maryland a or 28a-f sh iiffed at once Director	10e. Street and Number		10g. Citizen of What Country?
vith the s 23a o E notifi	2730 Fort Baker Drive, S.E.	20020 13. Was Decedent of Hispanic Origin? (Specify Yes or N	U.S.A. o- 14. Race - American Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after rral", o niner i	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: Black 116b. Kind of Business/Industry
72 hour n "natu al Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)	Tob. Kind of Businessanioustry
5-0036 lied within 72 hour Hygiene. lother than "matu the Medical Exan Completed	12	Laborer	Self Employed
215-(be filed v ntal Hyg rked oth ent, the Be Cc	17. Father's Name (First, Middle, Last) Wilber E. Brown	18.Mother's Name (First, Middle, Robin L. Grant	•
212 rould by d Ment d Ment is mark tic ever	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number of R	
MD and 2 sho salth and em 27 is raumati	Robin L. Grant Mother 20a. Method of Disposition 20b. Pla	2730 Fort Baker Dr., S.E., Vace of Disposition (Name of cemetery,	Nashington D.C. 20020
Baltimore, permit. Pages I al Department of He Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State	ematory or other place) August 18, 2010 Propolitan Funeral Service	Alexandria, Virginia
altirr mit. Pa partmer portan ury or	4 Donation 5 Other Specify: MEC 21. Signature of Funeral Service Lice e		
	halfilming MO066	1 42/0 Hawerottie Ra., Thate	an Head, Md. 20640
Physician /Medical	failure. List only one cause on each line.	oo not enter the mode of dying, such as cardiac or respiratory an	rest, shock, or heart Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. GUNSNOT WOUND OF HEAD Due to (or as a consequence of):		
je je	Sequentially list conditions, if any, leading to immediate b		
led nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
and and	d. UNPENDED AMENDED		
	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregna	incy	23d. Date of delivery
68760, certificate be uning physicises as the buritant/Medi	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of deat	2 Fetal death 3 Ectopic pregnancy	Month Day Year
Box e death contract the attended for use	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medic	Part II. Other significant conditions contributing to death but not resu		obacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown
Records, The law require, ate has been sig age 2 should be ompleted		24a. Was	
(eco) The law ate has age 2 si		auto _l perfo	ormed? death?
ician: 1 icertific rector, p	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
of Vit Physic er this eral dire	1 Yes 2 No 1059nai. 1 Inpatient 2 E		Residence 6 V Other: Scene
ision of Attending Physic death. by the funeral by the funeral cation: Testion: Testion ication: Testion ication icat	1 Natural 5 Pending Aug 12, 2010	0000 hrs 1 Yes 2 ✓ No Subject sho	
Division o spital or Attending hours after death. neral Director: After filled in by the func Certification:	3 Suicide Could not be	or Town.	Street and Number or Rural Route Number, City State)
Divi: To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedical Certific	29a. Certifier	Apt. 1000 Mercy A , death occurred at the time, date and place, and due to the cause	Avenue, Oxon Hill , MD
To the Hos within 24 h To the Fur completely		Vor investigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
BBM	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
BOW	30. Name and address of person who completed cause of death (Item 2:	O.C.M.E.	August 13, 2010
1	Victor Weedn MD JD Assistant Medical Examine		
State Registrar	101111s 115 7(17111 77)	1. back	
registia	A		

			For State Registrar	State of	Marylan	id / Depa <i>Cer</i>	artmen <i>tificate</i>	t of H	lealth a Death	and M	lental Hy	gien Reg. N	4 0	110	27	012
	Physicia		1. Decedent's Name (First, Middle Darryl	e, Last)	Gay						2. Date of De Month Augus	eath		010	3. Time of 5:15	
~ .	Medio Examir		4a. Facility Name (if not institution	, give street and numb			4b. City,	Town, or	Location of	of Death	Augus	$\overline{}$	c. County		p.13	a.
-			14756 Patton	Way			So	cot1	and					Mary	/¹s	
	Funeral Director		5. Social Security Number 213-42-9413	6. Sex 1 X M 2 ☐ F	. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Di 02/13/	th ay, Year, 194	3	Coun	olace (State try) ingto:	•
	d tow	_	Usual Residence of Decedent 10a. State 10b. County	-	100 Cit	y, Town or Lo	nation									
	Marylan 28a-f sh otified a	Director	Maryland St. Ma			:land	cation								0d. Inside (s 2 X No
	h the	a D	10e. Street and Number				10f. Zip	Code				10g. (Citizen of V	Vhat Cour	ntry?	
	th wit	Funeral	14756 Patton				206						ted	State	S	
98	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Manital Status 1 ☐ Never Married 2 🛣 Mai 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	es? 2 🗌 No	ff	Vas Deced f Yes, spec □ Yes 2	ify Cubar	n, Mexican	, Puerto I	cify Yes or No Rican, etc.)	-		k, White,		
9	hours natura ical E	ete	15. Decede	nt's Education	es.	16a. Deced	lent's Usua	l Occupa	ation			16h	te			
21215-0036	in 72 l e. na n "r Med	dmo	(Specify only high Elementary/Seconday (0-12)	est grade completed) College (1-4	l or 5+)	(Give I	kind of wor O NOT use	k done di	uring most	t of workii	ng	100.	uusu y			
	ygien ygien her th		12			Maste	r Car	pet	Mecha	nic		Ca	rpet			
Maryland	e filec tral H ed otl	To Be	17. Father's Name (First, Middle,	•			18. Mother's Name (First, Middle, Maiden Surname)									
N N	d Mer d Mer mark matic		Charles Frank 19a. Informant's Name/Relations			T					helmina					
Ma	2 shouth and the shou		Mary Elizabeth			1					l Route Number land, l		or Town, S 2068		Code)	
ē,	1 and if Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of			Date	1	Location -		wn, State	
E	Page nent c int: If iry or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (3 ☐ Removal from S Specify)	emetery, cren	-			18/19	9/2010	Cha	rloti	te Ha	11. M	D	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service	. Name and	d Addres	s of Facilit	y B ri	nsfiel	d Fu	ınera	1 Hor	ne, P.	Α.			
-	20 5 20	C.JS	Shawn Ayleswo		21						l., Leo		ltown	, MD	20650)
	Fnysician,	774	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	used the deat h line.	O)	er the mode		g, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be Onset and	etween
-	Medical Examiner		resulting in death)		r as a consequ		7000							\neg	1 Agen	~
	Lxammer	ř	Sequentially list conditions,	b. —												
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of impury	Due to (o	r as a consequ	uence of):										
	ate be executed bhysician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	uence of):			_					_		
09	siciar siciar buria	dical		d												
	ificate g phy as the		In service													
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregna	irth 2 Teta ant at time of o	al death 3	Ectopic p		у			ļ	23d. Dat Mor	te of deliventh	ery Day	Year
O. E	t the de by the tached	hys	9 Unknown	9 ∐ Unkno												
ls, P.O.	uires that signed k	Completed by F	Part II. Other significant condition		ath but not res	ulting in the u	nderlying c	ause give	en in Part I	l. 					ne cause of	
0.00	w require s been sig should k	plet									24a. Was		24b. V	Vere auto	osy findings	available
Rec	The law cate has page 2 t	mo.		-				auto perfi 1 \square Yes	psy ormed?	No. 1	nor to co leath? □ Yes	mpletion of	cause of			
[a]	i cian: The certificate ector, pag	Be (25. Was case referred to medical examiner?					26. Pla	ice of Deat	th (Check						
Ş	Physic this or	은	1 Yes 2 No		patient 2 -				4 L Nu		me 5 🔀 Resi)	
0	ding I h. After funer	ate	28a. Date of injury 1 Matural 5 Pending (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 2 Accident Investigation M 1 Yes 2 1								28d. Describe	how inju	ury occurre	ed		
Division of Vital Records,	If or Attendii after death. Director: At d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At ho	me, farm, stre			Yes 2 □	-	28f. Location (Street a	and Numbe	r or Rural	Route Num	her
ΟįΣ	al or A s after I Directed in by		4 ∐ Homicide detern	building	g, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,			Į.	City or To			or riurar	riodie rigin	Der,
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L Medical I	Physician: To the best	of examination	n and/or invest	igation, in n	ny opinior	n, death oc	curred at	the time, date	and plac	ce, and due	to the car	use(s) and m	anner stated
	To the I within 2 To the I complet	Σ	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: To	the best or my	y knowleage, a		License		and place	e, and due to the		ate signed			
			1 John C	Bounit	up		10	00 1	965)				1/2		
			30. Name and address of person			23a) (Type, P						_	- / - '	, 00	-,0	
me	-		John L. Benn	·			e Mil	1 Rd	., Ca	alifo	rnia,	MD	20619)		
	Sta Registra	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature istrar														

DHMH 17 Rev 7/2009

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined

29 2010 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home

🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

281. Location (Street and Number of Bural Roy 4 Number, City or Town, State) 1321 Hol Mr Ay
Silver Spring MD 20906

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

4 Homicide

29c. License number D45176 29d. Date signed (Month, Day, Year) Aug. 10, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hing-Chung Lee M.D. 6000 Executive Blvd. #300 Rockville, Md 20852 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature mende

Hospital

the

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <u>5:</u>45 ^{A™} Physician/ 2010 <u>August</u> Helwiq Charles Weaver Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mary's St. Mary's Hospital <u>Leonardtown</u> Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ₺ M 2 🗆 F 89 Yrs. March 26. West Virginia **Director** 579-14-6387 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛭 No St. Mary's Hollywood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20636 45214 Saint Cuthbert Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates.1940-1952 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **PEPCO** Electrical Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mary Anna Nipps Charles August Helwig other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1955 B. Division Lane, St. Leonard, MD 20685 Peter Thomas Helwig / Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State August 18,2010 Hollywood, Maryland St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition Con yester Pnysician/ Medical resulting in death) Due to (or as *consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day 9 Unknown P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Onknown page 2 should be Records, 1 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 1 Yes 26. Place of Death (Check only one) **Division of Vital** the funeral director, Be 25. Was case referred to medical examiner? 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural work?
1 Yes 2 No 5 Pending М death. Investigation 6 Could not be Accident after deatl 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after de To the Funeral Directo completed filled in by ti 4 Homicide City or Town, State 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, HD 20636 5 Rme 31. Date filed (Month, Day, Year) 32. R gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20/0 Robert Winfield Jackson, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TENINSULA ROGIONAL WICOMICO 5 HL135414 Birthpic Country) NY 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 № M 2 🗆 F (Month, Day, Year) Months Days Hours **Director** 078-10-6626 94 Usual Residence of Decedent of Health and Mental Hygiene, item 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Worcester Berlin 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7406 Libertytown Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Feed Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic Robert W. Jackson, Sr. Margaret_Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7406 Libertytown Rd., Susan J. Todd / daughter Berlin. MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Buckingham Cemetery 8/7/2010 Berlin, MD 22. Name and Address of Facility Signatur of Funeral Se ice Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest suck, or a lart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ENAC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Dav ed by the a detached f 1 Yes 2 9 Unknown g Unknown P.O. signed by d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ENIENTIA 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy death? performed Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe leted cause of death (Item 23a) (Type, Print) DN 6+1 HIRZ State

DHMH 17 Rev 7/2009

Registrar

Year

2010

4c. County of Death

27016

3. Time of Death

19:350

Physician /Medical Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division of Vital Records, P.O. Box 68760,

١ ,	Social Security N	lumber 6.	Sex 7.7	Age (In yrs. la	ast birthday)	If Under 1 Yea			rth	9.1	Birthplace (State or I
	579-46-85		1☐M 2□F		73 Yrs.	Months Day	s Hours Min.	oct. 6,	1936		MD
	Usual Residence of 10a. State	Decedent 10b. County		10c City	, Town or Loc	ation					10d Incide City
ō		Tob. County	a. .	Toc. City							10d. Inside City
Director	MD 10e. Street and Nur		Calvert		Hu	ntingtown			10 000		
		ber Court				10f. Zip Code	•			zen of What	Country?
Funeral	11. Marital Status	cer court	12. Was Deceder Armed Forces		5. 13. V	20639	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or N	US	14. Race - A	merican Indian,
ρ	1 ☐ Never Marri 3 ☐ X Widowed	ed 2 Married 4 Divorced	1 Tres 2 If Yes, Give] No		☐Yes 2K☐N		to nicari, etc.)		Black, W	nite, etc. hite
Completed	(Spec	15. Decedent's E	ducation rade completed) College (1-4o	.5.)	(Give I	ent's Usual Occ aind of work dor O NOT use reti	e during most of wor	rking	16b. Ki	nd of Busine	ss/Industry
ĕ	12	110017 (0.12)	College (1-40	1 3+)		Police C	fficer		Law	Enforc	ement
To Be (17. Father's Name	(First, Middle, Las Ihomas Klo	,				18. Mother's Nar	me (First, Middle		Surname)	
-8	19a. Informant's Na				19b. Mailin	g Address (Stre	et and Number or Ru	ural Route Numb	per, City o	r Town, State	e, Zip Code)
	William Jo	oseph Shav	er/Son	DOL DI			lemeade Driv				
	1 🔀 Burial 2		☐Removal from Stat	e ce	metery, cřem	ition (Name of atory or other p ln Cemet e	' ! ALK	Date 310	_	_	or Town, State Maryland
	21. Signature of Fu	neral Service Lice	I my	high	22 F) 500	Name and Add cancis J. Univers	ress of Facility Collins Fur ity Blvd. W	neral Home	Inc. Sprin	g,MD 20	901
	Immediate Cause (rt fallure. List only Final	nplications that caus one cause on each	ed the death. line.	Do not ente	r the mode of d					Approximate Interval Betwe Onset and Dea
	disease or condition resulting in death)	n (Due to (or a	s a con eque		cer					4
niner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	mediate rlving	b. Due to (or a	is a conseque	ence of):						
cal Examine	that initiated events resulting in death) L		cDue to (or a	s a conseque	ence of):						
Medi											
Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal of time of de	death 3 🗌	Ectopic pregna Other (specify)			2	23d. Date of Month	delivery Day Yea
ò	Part II. Other signif	icant conditions	contributing to death	but not result	ting in the un	derlying cause (given in Part I.				to the cause of dea
sted		ì						102	Yes ZL	1140 3	Probably 4 Uni
Complet								24a. Was auto perfo 1 □Yes	an psy ormed? 2 12 No		
Be	25. Was case referr examiner?	ed to medical	Hoopital				26. Place of Dea	ith (Check only o	one)		
유	1 Yes 2 ☑		·		R/Outpatient	3 L DOA		lome 5 Aesi			pecify)
io l	27. Manner of Death 1 Matural 2 Accident	5 ☐ Pending investigation		jury Day, Year)	28b. Time of Injury		ury at ork? □Yes 2□No	28d. Describe	how injury	occurred	
। ख्र	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of II	njury - At hometc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To	Street and wn, State)	d Number or	Rural Route Number
Certifical	- I nomicide										
edical Certification:	29a. Certifier	1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examination	ledge, death on and/or inve	occurred at the estigation, in my	time, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) date and	and manner place, and c	r as stated. due to the cause(s)
Medical Certifical	29a. Certifier (Check only	2∟ Medical Exa	miner: On the basis	of examination	ledge, death on and/or inve	estigation, in my	time, date and place opinion, death occurse number	urred at the time,	29d. Date	e signed (Mo	onth, Day, Year)
Medical	29a. Certifier (Check only one) 29b. Signature and the second of the sec	2 Medical Exa	miner: On the basis	of examination	on and/or inve	29c. Lice	opinion, death occu	urred at the time,	29d. Date	place, and c	onth, Day, Year)

			Please	Type or Pri								ole.			
	ical Uwar100ye Kan Imba Aug 10, 2010 09.30 u														
			e (First, Middle, La:	st)					2. Date of Dea	ath			3. Time of Dea	ath	
Physicia		Uwaribo	ove Kani	mba					- 1		2010	year	09:38	a ^M _	
Examin				street and number)			4b. City, Town, o	r Location of Death		4c.	County o	f Death			
and the same of th		Shady Gro	ove Adver	tist Hosp	ital		Rockvil		1		<i>fontgo</i>				
Funeral		5. Social Security N	umber 6. S	ex 7.7Ag □ M 2 🖵 F	e (In yrs. la	st birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)		Coun	olace (State or For	_	
Director		220-81-96 Usual Residence of	505	A	3	9 Yrs.			Feb 8.	1971			ongo D.R	•	
and show	ō	10a. State	10b. County		10c. City	, Town or Lo	cation	· ·				1	10d. Inside City Li		
Aaryk 8a-f tified	Director	MD	Montgon	ery	Ger	manto	wn						1 🗌 Yes 2 🤦	K No	
a or 2		10e. Street and Nur	nber				10f. Zip Code			10g. Ci	tizen of WI	hat Cour	ıtry?		
h with ns 23 must.	Funeral	20 Rockin	nham Cour			Lie	20874	U Ocioino (Co		Rwar		A-maria	an Indian		
deat riten inerr		11. Marital Status	ied 2X Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣		5.	Was Decedent of F If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)			, White,	etc.		
al", o	d by	3 Widowed		If Yes, Give Year or Dates.	INO		1 ☐ Yes 2x No	Specify:			Specify B	lack	5		
hours natur lical I	Completed	/Snc	15. Decedent's lecify only highest g			16a. Dece	dent's Usual Occup	oation during most of wor	kina		(ind of Bus				
in 72 ie. han "	ᄩ	Elementary/Sec		College (1-4 or	5+)	Ìife. L	OO NOT use retired,)	9	_		i			
be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be C	an Eulenia Nama	(Since Adiabatic Jaca)	2		Home	maker	18. Mother's Nar	ne (First Middle		Mn ho	ille			
e file ntal File ced or	일 B	17. Father's Name (Kan imba					Joseph		ishur					
should to and Me		Alexis 19a. Informant's Na		Type, Print)		19b. Mail	ing Address (Street	and Number or Ru				ate, Zip	Code)		
MIC Shalth ar alth ar 27 is r trau				atswe/ Hus	band			m Court;							
1 and 2 s of Health item 27		20a. Method of Dis	position		20b. F	Place of Disp	osition (Name of matory or other pla	ice)	Date	20c. L	ocation - 0	City or To	own, State		
Page 1 ment of ant: If it		1 Lx Burial 2 4 Donation	5 Other (Spec	Removal from State	³		o Cemeter	i i	20,2010	Ki	gali,	Rwa	anda		
portinition of and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	nera Service Licer	isee had		Þ	2 Name and Addre	eral Home	Drizzo (]ai+ì	harch	יייינו וי	MD 208	77	
7 gD = a o		· Cui	us c.	nplication that cause	d the deet						IETSC	urg	Approximate	-	
		shock, or hea	rt failure. List only	one cause on each lir	ie.								Interval Betwee Onset and Deat		
Medical		disease or condition resulting in death)		a. META 5T	ATIC a consequ	BREA uence of):	ST CANCE	ER TO LU	NG ANI	D BK	ZAIN	\dashv			
Examiner				METABO			515								
Λ	iner	if any, leading to in cause. Enter Under	mmediate	Due to (or as	a consequ	uence of):									
executed an and rial-transit	Examiner	Cause (Disease or that initiated event	ts	c. RESPIR Due to (or as			ALOSIS					-+			
	1=1	resulting in death)	Last	d. HYPOTE											
DIVISION OF VITAL RECORDS, F.O. BOX 901.00 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica			d	10210	N								-	
certifi nding use at	Ĭ <u>₹</u>	iF FEMALE: 23b. Was deceden		23c. If yes, outcome			☐ Ectopic pregnar	ncv		- 1	23d. Date				
death o	sicia	in the past 12 1 🔲 Yes 2	months? No	4 Pregnant 9 Unknown	at time of		Other (specify)				Mor	nth	Day Year	r	
t the c	Phy	9 Unknowi		contributing to death		ulting in the	underlying cause o	niven in Part I.	23e Did	tobacco	use contri	bute to	the cause of deat	th?	
ss tha igned be de		Part II. Other sign	meant conditions	contributing to death	Dat Hot To.	outing in the	and onlying dadde g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					obably 4 🗆 Unk		
een s	etec								24a. Was	s an	24b. V	Vere auto	opsy findings avai	ilable	
necords, The law requires ate has been sig	Completed								auto perf	opsy formed?	d	eath?	ompletion of caus	se of	
n: The lift of the		25. Was case refer	red to medical	T			26. I	Place of Death (Che	1 🗆 Yes	2 (2)	NOI 1	res	2 🗆 110	_	
VICAI ysiclan: is certific director,	To Be	examiner? 1 \square Yes 2	⊠ No	Hospital:	itient 2	ER/Outpati	ent 3 DOA Ot	her: 4 Nursing	Home 5 Res	idence	6 🗌 Othe	r (Speci	fy)		
of ng Phi ter thi neral		27. Manner of Dea	th 5 Pending	28a. Date of in (Month, D	jury lay, Year)	28b. Time injury	wo	rk?	28d. Describe	how inju	iry occurre	ed			
DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu	iji Eg	2 Accident	Investigati	te -				Yes 2 No	DOS La sation	(Ctue at a	nd Alumba	r or Dur	al Route Number,		
or At or At after of Direct in by	Certificate:	4 Homicide		28e. Place of Ir	njury - At h etc. (Specif	ome, farm, s	treet, factory, office		City or To			r or nun	ar noute reamber,		
Spital spital sours		29a. Certifier	1 X Certifying Ph	ysician: To the best o	of my know	/ledge, deatl	occured at the tim	ne, date and place,	and due to the c	ause(s) a	and manne	er as sta	ted.		
n 24 h	Medical	(Chook	2 Modical Eva	miner: On the basis of urse Practioner: To the	evamination	n and/or inv	estigation. In my onli	nion, death occurred	at the time, date	and plac	æ, and due	to the c	ause(s) and maining	er statet	
To the composition	-	29b. Signature and		12-12			29c. Licen	ise number	~		ate signed		, Day, Year)		
6				ABER				525.	۵ /		3/16	110			
4		30. Name and add		completed cause of	death (Iter	m 23a) (Type ΜΕλίι	Print) Print)	EP DRIVE	Rock	VILL	E M	HRY	LAND 2	0850	
Sta	ate	31. Date filed (Mor	ith, Day, Year)	2. Regis	trac's Sign	ure &	, Ked	ER DRIVE	. 10010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Regist		AL	IG 1320	10 Census	w fo	1. 190	T = 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Owayne Scott K	ay	St 1- For State	ate of Maryla	and / Depa		Health and		lygiene	20	10 27018		
Physici Medical Exam		1. Decedent's Name (First, Midd Dwayne Scott B		2. Date of Dea Month August 19	th	3. Time of Death						
		4a. Facility Name (if not institution St. Marys Hospital	•	mber)		4b. City, Town, or Leonardtown			4c. County o	of Death		
Funeral Director		5. Social Security Number 230-08-9356	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24Hi Hours Mi		th(MM/DD/YYYY) LO, 1963	9. Birthplace (State or Foreign Country) Virginia		
any		Usual Residence of Decedent 10a. State 10b. County	1 <u>X</u> M 2F	10c. City,	4 / Yrs			That chi	2703	10d. Inside City Limits		
	Director	Maryland St. M 10e. Street and Number	lary's		Hollyw	10f. Zip Code		1	0g. Citizen of Wh	1 Yes 2 No at Country?		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he notified at once	Funeral Dir	25925 Jones Wharf	12. Was Dec	edent Ever in U.		206 s Decedent of Hispa es, specify Cuban, I	anic Origin? (S		USA - 14. Race White	- American Indian, Black,		
rs after deat ural", or ite miner must	ρ	1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe	1 Yes orced If Yes, Give Yea or Dates:	2 X No	1	Yes 2 X No	specify:		Specify:	White		
5-0036 led within 72 hours s Hygiene. other than "natura the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1			ost of working life. D			Construc			
21215-0036 21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be Con	17. Father's Name (First, Middle, George Marshall Ka	•					e (First, Middle, I Sue West	Maiden Surname)			
MD 21 rd 2 should ulth and Me m 27 is ma	٩	19a Informant's Name/Relations Mary Sue Weaver/ N			25925	Address (Street a	Road, Ho	llywood,	Maryland	20636		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20c. Location - City or Tow August Alexandria, Vi										
	Ш	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral H P.O. Box 270 Leonardtown, MD										
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Hemopt		le de	e mode of dying, su	uch as cardiac	or respiratory arr	est, snock, or nea	rt Approximate Interval Between Onset and Death		
	Je.	Sequentially list conditions, if any, leading to immediate	b	consequence of	·							
ited 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	f):							
60, tte be executed hysician and e burial - transit	Aedical	X UNPENDED IF FEMALE:	AMENDED	23a,27		g908 10-1	l5-10 v	t	23d. Date of	delivery		
Box 68760, e death certificate by the attending physic ed for use as the bur		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Univ	1 Live bi	irth ant at time of de	2 Fel	al death 3 er (Specify)	Ectopic pregn	ancy	Month	Day Year		
ires that the signed by the detache	ā	Part II. Other significant condit	ons contributing to	death but not re	esulting in the u	nderlying cause give	en in Part I.	-		oute to the cause of death? Probably 4 Unknown		
Records, The law requir icate has been s	Completed	24a. Was an autopsy findings an autopsy performed? 1 Ves 2 No 1 Ves 2										
of Vital Reco ling Physician: The law After this certificate has funeral director, page 2 s	To Be	1 Ves 2 No Indiana 2 ER/Outpatient 3 DOA Survey 1 Norsing Home 5 Residence 6 Other:										
tence eath	Certification:	3 Suicide 6 Coul	ling stigation		ome, farm, stree	1 Yes		28f. Location (S or Town, S		r or Rural Route Number, City		
Divis To the Hospital or At within 24 hours after d To the Funeral Direct	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the best niner:On the basis o and manner st	f examination ar								
	¥	29b. Signature and title of certifie	U. Ken	g JR.	, na J	29c. License n		Ш	29d. Date signed August 20, 2	d (Month, Day, Year) 2010		
	ate	 N me and address of person Theodore M. King, Jr., Date filed (Month, Day Year) 	MD. Assists	nt Medical E	xaminer	111 Penn Stree	et, Baltimor	e, MD 21201				
St Regist	c											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	aryland / Dep		nt of Hea <i>te of De</i>			ieg. No.	0 2	27019
		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
Physicia /Medic	_	Liliana Yamileht	Lopez-Vasquez					August 1			10:46 a M
Examin		4a. Facility Name (If not institution	give street and number)		4b. City	, Town, or Loc	cation of Death)	4c. Coun	ty of Death	
		Montgomery General	Hospital			lney				ntgomer	y
Funeral Director		5. Social Security Number 212–89–4621	6. Sex 7. Ag	e (In yrs. last birthda O Yrs.	y) If Undo		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 19,	2016	9. Birthp Cour	place (State or Foreign ntry) Maryland
D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						Od. Inside City Limits
aryla ehon	٦										1 ☐ Yes 2 ☐No
788-f	ecto	Maryland M 10e. Street and Number	on tgomery	Silver		ip Code			10g. Citizen o	4 14/h - A Cour	
desth with the Maryland rms 23a or 28s-f ehow rnst be nutified at	Funeral Director	3916 Tynewick Dri	<i>r</i> e		101. 2	20906			USA	What Cour	iu y r
ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 1:	3. Was Dec	edent of Hispa	inic Origin? (S	pecify Yes or No-	14. Ra	ace - Americ	can Indian,
_ i = i	by Fun	t Never Married 2 Marr 3 Widowed 4 Divorced	Amed Forces?		If Yes, sp	ecify Cuban, N	dexican, Puert Specify:Salva	o Rican, etc.)	ВІ	lack, White, ;ify: Whit e	etc.
5-UUSG 72 hours at neture!; or alcal Exem		15. Deceden		16a. Dec	edent's Us	ual Occupation	n		16b. Kind of	Business/in	dustry
U Z uin Z	piet	(Specify only highes	t grade completed)	(Gi	ve kind of w		ng most of wor	king			,
d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Nor	ne			İ	N	/A	
d be file ontal Hyg ed othe	BeC	17. Father's Name (First, Middle,	Last)			18.	. Mother's Nan	ne (First, Middle,	Maiden Suma	ame)	
should b and Menta and Menta and marked	To	Yunin Nahum Lope:	z				Iris Mat	el Vasquez	Z		
and tem		19a. Informant's Name/Relations	nip (Type, Print)	19b. Ma	iling Addres	ss (Street and	Number or Ru	ral Route Numbe	r, City or Tow	n, State, Zip	Code)
ore, M es 1 and 2 of Heelth of Heelth rother tre		Iris Mabel Vasque	z/Mother				ve, Silv	er Spring,			
ges 1 If its or oth		20a. Method of Disposition 1 № Burial 2 □ Cremation	3 Removal from State		rematory or	other place)	Aug.	Date 13,	20c. Location	1 - City or To	own, State
Saltimo bermit. Pages Depertment of mportant: if i iny injury or o		4 □ Donation 5 □ Other (S		Gate of I			201	.0	Silver	Spring,	Maryland
permit. Pages: Department of timportant: if ite any injury or of anger.		21. Signature of Funeral Service	cod M	Hugh!	Franci	and Address of s J. Col versity	llins Fur	eral Home , Silver S	Inc. pring,	MD 2090	01
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each lin	the death. Do not ene. ephaly (Cor				or respiratory are	rest,		Approximate Interval Between Onset and Death 3 weeks
certificate be executed certificate be executed certificate be executed and ording physicien and ordinal-transit case as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Cardiores</u> Due to (or as	a consequence of): piratory Arr a consequence of): a consequence of):	rest						
box cath certif	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ∐Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B Ectopic Double (1	Date of delive	ery Day Year
wrequires that the de been signed by the should be detached	by P	Part II. Other significant condition	ons contributing to death b	ut not resulting in the	underlying	cause given in	n Part I.		bacco use co		he cause of death?
10 6 5 CA	Completed							24a. Was autop perfor	sy	b. Were auto prior to co death?	opsy findings available ompletion of cause of
VICAL TA sician: The certificate hi rector, page								1 ☐ Yes	2 🔀 No	1 ☐ Yes	2 □ No
OI VILAI TE Physician: The I this certificete ha	Be	25. Was case referred to medical examiner?	Hospital:			Othor		ath (Check only o			
	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🗆 Inpatre			707		lome 5 Resid			fy)
ding h. Afte	ţ	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi		y Year) Injur		28c. Injury at Work?	2 □ No	254. 5556557	on injury ood		
DIVISION J or Attending after death. Director; Atte	ertification;	3 Suicide 6 Could determ	not be 200 Bloom of Inc	ury - At home, farm, c. (Specify)				28f. Location (S City or Tow	Street and Nu vn. State)	nber or Run	al Route Number,
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the best Examiner: On the basis o and manner sta	f examination and/or	ath occurre investigation	d at the time, on, in my opinio	date and place on, death occu	e, and due to the curred at the time,	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)
ompl	Me	29b. Signature and title of certifie	7	-	2	9c. License nu	umber		29d. Date sig	ned (Month,	Day, Year)
F > F 0) /m	Joka Viun	GRA MD		D59258	3		August	12, 20	10
		30. Name and address of person	who completed cause of d	leath (Item 23a) (Tvr	e, Print)						
		Jose Villagra,		ockville Pil		kville,	MD 20850)			
Sta Registr	_	31. Date filed (Month, Đay, Year)	32. Registr	ar's Signature	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 pay Physician/ 7:23 A Ronald B. Lambert 2010 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Nursing Home Frederick Social Security Number 6. Sex 1 █**X**M 2 ☐ . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Sept. 24, 1934 Director 233-58-3098 Virginia 75 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Directo Frederick Brunswick Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21716 United States 1025 Peach Orchard Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

X Yes 2 \(\text{No } 1956-Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 1960 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) +1Electromechanical Inspector Aerospace Be Department of Health and Mental Hy, Important: If item 27 is marked All any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thelma Hedrick Merle Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Foute Number, City or Town, State, Zip Code) 1025 Peach Orchard Lane, Brunswick, MD 21716 Barbara Lambert / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hedrick Cemetery 8/13/2010 Seneca Rocks, WV 21. Signatura of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1100 N. Maple Ave., Brunswick, MD part 1. Enter the dilea and complications that cause, or heart failure. Only one cause on each complications that cau ed death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death? page performed? Yes 2 No 2 🗌 No 1 Yes Hospital or Attending Physician: 124 hours after death.
Funeral Director: After this certifica sted filled in by the funeral director, p 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 2 No ☐ Acciden☐ Suicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vital

Division of

80

NV

, M

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#2perMD, 8/20/10, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 5:30а м Max Mudrick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Rockville Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 01/30/1921 1 X M 2 🗆 F Months Days 579-18-1355 89 Washington. **Director** Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10a State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 52a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Leisure World Blvd., 20906 3210 N. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Liquor Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Finkelstein Israel Mudrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 N. Leisure World Blvd., #508, Silver Spring, MD Florence Mudrick - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 💹 Burjat 2 🗆 Cremation 3 🗷 Removal from State King David Mem. Grdns 08/12/2010 | Falls Church, VA 4 Donation 5 Other (Specify) 21. Sign ture of uneral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M00709 Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 h. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the dise shock, or heart falur Immediate Cause (Final Onset and Death Physician/ Hypertensive Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Heart Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a subsequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus resulting in death) Last Physician/Medical Congestive Heart Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day Vear 5 Other (specify) Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗶 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J'OSER M Womas D0047330 August 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. Edmonston Drive, Suite 207, Rockville, Maryland 20852 Joseph. Thomas V.

State Registrar 31. Date filed (Month, Day, Year)

Physician /Medical Examiner P.O. Box 68760,

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010^{ear} **Physician** August 17 12:05 P ^M Mullendore Noah Leo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington 14 McKeldin Drive Boonsboro 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F **Funeral** Months Days Hours Maryland 220-28-2970 79 Director 1931 March 7. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 1 X Yes 2 No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21713 14 McKeldin Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Dve and Finishing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith ဥ O. Mullendore Helen Noah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 McKeldin Drive Boonsboro Maryland 21713 Ruth N. Mullendore/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-21-2010 Boonsboro Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home. PA 21. Signature of Funeral 7606 Old National Pike Boonsboro. MD Approximate Interval Between Onset and Death 23a. Part 1. Eni if the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an leart failure. List only one value or each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-5 21 WYAND DR., KEEDYSVILLE, MD 21756 ROBERT GUEDENET, MD 31. Date filed (Month, Day, Year, State AUG 18 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of State Amend Items 23aPtI, Registrar	Maryland 25 per	me g9	ortment of 06,08/2/ tificate of	f2010 Death	and M			110	27023
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) RoßeR+ 4a. Facility Name (If not institution, give street and numble)	Der)	M	each A	nr Location o	of Death	2. Date of Dea	23	2010 anty of Death	3. Time of Death 5', 29 PM
	Examin		The Johns Hopkins Hospital			Baltimore	City		•	F	BALTIM	ORE CITY
	Funeral Director		5. Social Security Number 125-30-9292 6. Sex 1 ★ M 2 □ F	'. Age (In yrs. Ia 70	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Da 1/29	th y, Yea <i>r)</i> /1940	9. Birth Cou	nplace (State or Foreign ntry) ILLINOIS
	т.		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryla a-f sho	ctor	MARYLAND TALBOT				WITTN	/AN_				1 ☐ Yes 2💢 No
	with the	Director	10e. Street and Number 22580 POT PIE ROA	VD.		10f. Zip-Code	2167	16		10g. Citizen	of What Cou	
	ems 2	Funeral	11. Marital Status 12. Was Deceder Armed Force	lent Ever in U.S	. 13.\	Was Decedent of f Yes, specify Cub			cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	ican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married Married 1 Yes 3 Widowed 4 Divorced Year or Dat			1 ☐ Yes 2 ☑ No					ecify:	WHITE
5-0036	72 hou "natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occu kind of work done OO NOT use retire	during mos	at of workin	ng	16b. Kind o	of Business/	Industry
2121	be filed within 72 tal Hygiene. d other than "nate event, the Medica	dmo	Elementary/Secondary (0-12) College (1-4	or 5+)		ADDICTIO	,	SELO	2		COUN	SELING
pu	be filed ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)	VXI			18. Moth	er's Name	(First, Middle	n, Maiden Sur DIA TRA		
Maryland	should and Men s marke umatic e	욘	UNKNOV 19a. Informant's Name/Relationship (Type. Print)	VN	19b. Mailir	ng Address (Stree	t and Numb	er or Rura				ip Code)
∑. Z	and 2 sauth ar n 27 Is		JUDITH MEACHAM / WIFE				2580 PO		D., WITT			
nore	ages 1 nt of Hi ; If iter		20a. Method of Disposition 1 ☐ Burial 22 Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	tate C6	emetery, crer	osition (Name of matory or other pla LEMATION CE			2010		on - City or i	IDGE, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai		21. Signature of Funeral Sovice Licensee	MIDS		2. Name and Add						
ä	l m		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each	used the death							D., CAM	BRIDGE, MD 21613 Approximate Interval Between
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (conditions)	or as a consequence of the order	ence of):	£-			1			Onset and Death
JML Box 68760,	ificate be executed g physician and as the burial-transit	edical	that initiated events resulting in death) Last C Due to (c d	or as a consequ	ence of):		CERTIFIC	TYON APPR	OVED BY MEDI	M. Ev.		3
(to MS	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	rth 2 Fetal ant at time of de wn	death 3 ath 5	Ectopic pregnar Other (specify)			1		Date of del Month	Day Year
ds, F	requires that the een signed by th hould be detach	β	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the o	underlying cause	given in Par	t 1.	23e. Did			o the cause of death?
23a t I Record	The lar te has page 2	Completed							1 X Yes	psy ormed? 2 \(\) No	24b. Were au prior to death? 1 \(\sum \) Yes	utopsy findings available completion of cause of
# SE	s Iclan : certific lirector,	Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 1	npatient 2 🗆 I	ER/Outpatier	nt 3 DOA O	hor:		ne 5 ☐ Resi		Other (Spec	cify)
on of	ding Phys h. After this funeral d	tion: To	27. Manner of Death 28a. Date o		28b. Time o Injury	of 28c. Inj			28d. Describe	_	ccurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 28e. Place	of injury - At hor g, etc. (Specify)	me, farm, str	reet, factory, office			28f. Location City or To		lumber or R	ural Route Number,
	Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier 1 Certifying Physician: To the base one) 2 Medical Examiner: On the base and mann	sis of examinat	vledge, death ion and/or in	h occurred at the ivestigation, in my	time, date a opinion, de	nd place, eath occur	and due to the red at the time	e cause(s) an e, date and pl	nd manner a lace, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	M	D	29c. Licer	se number	A. A.		29d. Date s	igned (Mont	h, Day, Year)
	ຸກ		30. Name and address of person who completed caus	e of death (Item	23a) (Type,	, Print)	とフー	UU)]	Vi	J/Y 2	7,000
	10		BERLI JENS	М.	<u>v.</u>			600 1	North We	olfe St,	Baltime	ore, MD, 21287
	Sta Regist	ate rar	AUG 2 7 2010	gistrar's Signat	A. A	and						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month + ugu 5 Physician/ RAYMOND LAMAR MONEY 0144 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 M 2 🗆 F Months 09/09/1931 **Director** 578-40-0306 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f MD MONTGOMERY POOLESVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20837 17628 SOPER STREET USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married þ mond ///00ピリ more, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: WHITE and Mental Hygiene.

is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTER PARK SERVICE 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve anse. AUBREY MONEY EMMA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA CROSS / DAUGHTER 17628 SOPER ST., POOLESVILLE, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date NORBECK MEMORIAL 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State OLNEY, MD 08/14/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BOX 86 P.O. HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No the s g 🗌 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebral Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 cate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Year

			For State Registrar		S	State of	f Ma	ryland			tment of F			Mental H	ygier Reg. 1	20	10	27
	Physici /Medic		Decedent's Nam Phuong 1											2. Date of Month	Death	Эау	Year	3. Time 9:25
	Examin		4a. Facility Name (i				nber)				4b. City, Town, o	r Locatio	n of Death	1		4c. County	of Deat	h
			Sanctuary	at Holy	7 Cross	S					Burt	tonsvi	lle			Monto	gomer	У
4247	Funeral Director		5. Social Security N 220-41-88		6. Sex 1 ☐ M	2 ₹ 1 F	7. Age	(In yrs. I			If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min.	8. Date of l (Month, Dec. 25			9. Birt Co	hplace (Stat untry) Vietn a
	pu ,		Usual Residence o					10c. City	Town	071.00	tion							10d. Inside
	larylan show ed at	-	10a. State	10b. County				TUC. City										10d. Inside
	the Ma 28a-f	Director	Maryland		P.G.				Bel	svi		-			T			
	or 2	Dire	10e. Street and Nu		D						10f. Zip Code				10g.	Citizen of \	What Co	untry?
	ath w		1100Z NE	eartwood							20705					USA		
	items items	Funeral	11. Marital Status	v		Was Dece Armed For	rces?		3.	13. W	as Decedent of H Yes, specify Cub	lispanic (an, Mexic	Origin? (S an, Puert	pecify Yes or o Rican, etc.)	No-		e - Ame ck, White	rican Indian, e, etc.
980	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by	1 ☐ Never Mari 3 ☐ Widowed	_	1	1 □ Yes If Yes, Giv Year or Da	/e	0		1 [∐Yes 21 € No	Specia	fy:			Specify	v: A	sian
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Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryls f Health and Mental Hygiene. tem 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name Dien Van		Last)									ne (First, Midd Duang	dle, Maic	len Surnan	ne)	
2	2 shou and M Is mar	F	19a. Informant's N	ame/Relations	ship (Type.	Print)			19b.	Mailing	Address (Street	and Nun	ber or Ru	ıral Route Nui	nber, Cit	y or Town,	State, 2	Zip Code)
Z	nd 2 statth at 27 ls		Nam Van N			,			11	802	Heartwood	Driv	e. Rei	ltevilla	MD	20705		
<u>6</u>	f Health tem 27		20a. Method of Dis					20b. P	lace of i	Disposi	tion (Name of atory or other pla	cel		Date			City or	Town, State
10	Pages nnt: If It		1 ☐ Burial 2 4 ☐ Donation			noval from	State				Cremator		Augus 201	st 14	7.7	or mondu	.i. 1	7A
Baltin	permit. Pages 1 and Department of Health Important: If Item 27 any in Jupy or other troope.		21. Signature of F			1-22	191	1, 9	2	Fr	Name and Addre	ollin	cility S Fune	eral Home	e Inc	exandr •		
			23a. Part1. Enter	the disease of	complicat	tions that o	aused i	tho death	Don		Universi					ing, MD	2090	
			shock, or hea	art failure. Lis	only one	cause on e	ach line	9.										Approxir Interval I Onset a
٦,	Physician /Medical	3 11	disease or condition resulting in death)	on	a	m	10t	as	ta	HC	Cho	lan	310	carci	mo	ma		
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No.		<u>.</u>	Sequentially list co	onditions,	b	Constal	liese s	Corisey	runea d	Pie-								
	sit ed	ine	Sequentially list confirmany, leading to in cause. Enter Undo Cause (Disease or	erlying -	2	Due to ((UI as a	Consequ	131106 0	,.								
	ecut and I-tran	Examiner	that initiated event resulting in death)	S	C	Due to /	(or as a	consequ	ience o	f)-								
60,	be e) cian ouria					20101	(0. 00 0			.,.								
68760,	cate ohysi the I	di			d													
Box 6	death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was deceder in the past 12	2 months?	23c.	. If yes, out 1□Live b 4□Pregr	oirth 2	2 ☐ Feta	death		Ectopic pregnanc Other (specify)	÷y					ite of de	livery Day
Ö	the a	ysi	1 ☐ Yes 2 th 9 ☐ Unknown			9□Unkno					(-2001)/ =				_			

Physi Completed by Be မ

Certification:

To the Hospital or Attending Physician: The law requires that the owithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical

Division or Vital Records, P.O.

Sta Registr

2

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ate	31.	Date	file	d Y M	onth,	Da	y,	
					10	4		1

25. Was case referred to medical examiner?

2016

5 Pending investigation

6 Could not be determined

1 ☐ Yes

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No

Other:

28c. Injury at Work?

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3□ DOA

M

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9:25 a

 Birthplace (State or Foreign Country) Vietnam

> 10d. Inside City Limits 1 ☐ Yes 2 ☑ No

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

4 Nursing Home 5 Residence 6 Other (Specify)

2 | Ald

28d. Describe how injury occurred

1∐ Yes

26. Place of Death (Check only one)

1 | Yes 2 | No 3 | Probably 4 | Unknown

Year

30. Name and address of person 835 203

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Year) 22. Registrar's Signature 1 3 2010

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

þ

Completed

Be ပ္

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mantal Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 2 and 10 july or other traumatic event, the Mediesi Event.

attending pl ed by the a within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the Hospital

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
ıysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
pleted by Ph	Part II. Other significant conditions of	ontributing to death but not resulting in the under	iying cause given in Part I.		o use contribute to the cause of death? 2				
To Be	performed? death 1								
	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	27. Manner of Death 1 Manual 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in					
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	ctory, office 28f. Location (Str City or Town		eet and Number or Rural Route Number, State)				
edical (29a. Certifier (Check only one) 1AC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Ž	29b. Signature and title of certifier		29c. License number	29d. I	29d. Date signed (Month, Day, Year)				

Registrar DHMH 17 Rev 1/2001

State

COPAGE RIDGE, 710 Obrecht Rd, Sykesville

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

CRNP. Cop.
32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

OS: Horace

Cicens

Known to Physi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 11:45 рМ Edmunds Praulins, Sr. 3 August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jun 9, 1924 9. Birthplace (State or Foreign Country) Latvia . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★ M 2 □ F 579-52-0636 86 Director Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State Director MD Montgomery Rockville 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9539 Viers Drive, #2 20850 USA "natural", or items 23: edical Examiner must or items . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No White Specify: 3X Widowed 4 □ Divorced Completed Year or Dates 7 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) computer technology Manager n and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill be the second that and Mental item 27 is marked 2 Janis Praulins Alida (last not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uldis Elstins/ Personal Rep 2004 Kings House Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ₽ 1 X Burial 2 Cremation 3 Removal from State 'n Rock Creek Cemetery injury o 4 ☐ Donation 5 ☐ Other (Specify) Aug 13, 2010 Washington DC 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Euneral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final disease or condition Physician hock Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a conse attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes ☐ No detached for Month Dav Pregnant at time of death the g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ the funeral director, page 2 should be The law requires 2 No Records, 1 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a Was an has autopsy performed 1 🗌 Yes 2 🗆 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. May of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending М 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

raulins, Edmund completed filled in by Medical 29b. Signature and title of certif 29c. License number 29d. Date signed Month. who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 8600 Old Georgetown Rd, Bethesda, MD 20814 31. Date filed Month, Day, Year 32. Registrar's Siğ State 13 Registrar

34:11

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10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 29d per med cert G907 9/10/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ рМ Mary Frances Patrick August 2010 7:07 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil El kton Union Hospital of Cecil County If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Funeral Year) 1940 Maryland Days Feb. 13 1 🗆 M 2 🗶 F Min. 70 Director 212-40-7182 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🌠 No Cecil Port Deposit Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21904 22 Maple Hill Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. 11 Marital Status Black White, etc. 1 Never Married 2 M Married Ď 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Personal Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ٥ Bessie Wright Stanley Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 21904 22 Maple Hill Drive, Port Deposit, Maryland Joseph G. Patrick, Sr. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Perryville, Maryland 08/17/10 Principio Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home.
Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as ca diac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a eunesquence of: attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav 4 Pregnant a Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only or 29d. Date signed (Month, Day, Year) the of certifier 29c. License number 29b. Signature September 1, 2010 and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2010 Year Physician/ 5:55 p. M August 7, Francis Huan Pham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Frederick **Examiner** Frederick Citizens Care & Rehabilitation g. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral ^{Year} 192<u>6</u> Days Hours 1 🛛 M 2 🗆 F Viet Nam 84 Director 586-34-8476 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryiand ment of Health and Mental Hygiene. The street of thems 23a or 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f show iury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 94 Buell Court, Frederick, 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tax service Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Suy Thi Pham An Trong Pham 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Buell Court, Frederick, Maryland 21702 Department of Heatth at Important: If item 27 is any injury or other trau Mai Loan Pham - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗓 remation 3 ☐ Removal from State 8-10-2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEMILE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \square No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 20061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRAFFAR 801 TOLL HOUSE

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ Helen Mae Payne 2 2010 07: 25 AM Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WICOMICO usbun Hospic 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Hours Min 07/14/19 Country) Maryland 212-34-7311 Director 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏿 No Wicomico Mardela Springs Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21837 25575 Rising Eagle Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Burnett Reese Mae Louise Brosker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25575 Rising Eagle Rd., Mardela Springs, MD 21837 George J. Payne Sr/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Springhill Memory Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/16/2010 Hebron, MD Donation 5 Other (Specify) . Signature of Foneral Service Licenses 2Horroway Poneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP MOMUNION 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ VOMIC lomonos disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that believed as or the cause (Disease or linjury) Examine Due to (or as a consequence of, and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ☐ Pregnan. ☐ Unknown signed by the a 9 Unknow P.O. I Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has page 2 s prior to completion of cause of death? this certificate 25. Was case referred to medical Division of Vital After this certific funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes ျှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? _1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: A pompleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 [29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

2010

AUG 13

Patient Known of DOREHTHA ROWDY Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, (\$\frac{1}{2}\) Baltimore, Mary lossital or Attending Physician: The law requires that the death certificate he executed to the control of the

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Examin	ner			IL OF BALTI	4.04	_	a.	r Location of Death	4	c. County of Dea	ıtn	
Funeral		5. Social Security N	lumber 6	. Sex 7. Ag		ast birthda	17.11 () ()	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year 3/18/193	9. Bi	rthplace (State or Foreign ountry)	
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land ow		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or	Location	<u> </u>			10d. Inside City Limits	
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or 28		10e. Street and Number 2001 15th Street NW Apt.					10f. Zip Code	200		itizen of What C	ountry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Maryland Examiner must be notified at once.	eral	2001 15	tn Str	12. Was Decedent		904		009		USA 14. Race - Am	erican Indian	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with the Funeral Director. After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the temporal process.	Physician/Medical			u								
ath cel ttendir or use	an/N	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outcome 1 Live birth			3 □ Ectopic pregnan	су		23d. Date of d	elivery Day Year	
he dez the a	ysici	1 ☐ Yes 24 2 9 ☐ Unknown	≥ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath	5 ☐ Other (specify) _			World	Day Tour	
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Physer this eral dii	Certification: To	1 ☐ Yes 2 ☐ 27. Manner of Deat		28a. Date of Inju	ry	28b. Time	of 28c. Inju	ry at 2	le 5 ☐ Residence 8d. Describe how inj		ecify)	
ath. r: Afte	atio	1 Accident	5 ☐ Pending investigat	(Month, Da	y, Year)	Injur		rk?]Yes 2 □ No				
r Atte ter de irecto	tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determin		ury - At ho	me, farm,	street, factory, office	2	8f. Location (Street : City or Town, Sta		Rural Route Number,	
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Hosp 24 ho Fune etely f	Medical	29a. Certifier (Check only one)	2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examina	wledge, de tion and/o	eath occurred at the t r investigation, in my	ime, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner and place, and da	as stated. ue to the cause(s)	
To the within To the comple	Me	29b. Signature and	title of certifier				29c. Licen	se number		Date signed (Moi		
(Ka) MBBS RESOOO							A	AUG 08, 2010				
24		30. Name and addr	ress of person wh	no completed cause of d			e, Print)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeanette C. Rohls August 2010 РМ 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2650 Pinewood Drive Waldorf Charles 9. Birthplace (State or Foreign Country) Mary land 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year, 1 🗆 M 2 💢 F Months Hours Min. Director 579-01-7499 94 1915 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1**X** Yes 2 No <u>Maryland</u> Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>2650 Pinewood Drive</u> 20601 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. iant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 10th. <u>Home Maker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Simms Augusta Shemonsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rohls/ Son <u> 2650 Pinewood Dr. Waldorf, Maryland 20601</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 17, 2010 Brentwood. <u>incoln Cemeterv</u> :Aua 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can be on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BNOW disease or condition Medical resulting in death) Examiner wow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of examination and a second of the past of my knowledge. death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier BBIN who completed cause of death (Item 23a) (Type, Prin

5

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Frederick Ridgell 2010 George 9:32 <u>August</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 50345 Scotland Beach Road Scotland 9. Birthplace (State or Foreign Country)
Maryland . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Hours 03/04/1940 1 😿 M 2 🗀 F Months Director 70 216-40-7919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No St. Mary's <u>Scotland</u> Maryland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20687 USA 50345 Scotland Beach Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1

Yes 2 □ No
If Yes, Give Completed by 1 Never Married 2 K Married 1 ☐ Yes 2 K No Specify Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Government Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cecilia Ρ. King Joseph Α. Ridgell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50345 Scotland Beach Rd., Scotland, MD 20687 Joyce A. Ridgell/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 08/14/2010 Charlotte Hall, MD 4 Donation 5 Other (Specify) Brinsfield-Echols ign mentioneral state decensee
Edward N. Brinsfield, 21. Sign 22. Name and Address of Facility Brinsfield Funeral Home, P.A 22955 Hollywood Rd., Leonardtown, MD 20650 Jr.,M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 469 Sequentially list conditions il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or so a eur seu vence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗌 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? has autopsy performed? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag. 1 🗌 Yes 2 🗌 No Yes 2 E 25, Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 KR Residence 6 Cher (Specify) 욘 2 5-No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Hatural injury 5 Pending work 1 Yes 2 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

28227 Three Notch Rd., Mechanicsville, MD 20659

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishna Jayaraman,

AUG 16 2010

31. Date filed (Month, Day, Year)

M.D

12010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death rocc Physician/ 1027 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Jourdel GEN HOSP 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days 1 □ M 2 🛛 F Months Hours 3 70 9 7 9 2 4 Salem, MA 023-14-2036 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Prince George College Park MD 1x Yes 2 ☐ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 20740 9122 Bridgewater Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: should be filed within 72 hours aften and Mental Hygiene, is marked other than "natural", If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Tataronis Mary Pawasar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)21638permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 400 Narrows Pointe Drive Grasonville, Md James Strocchia/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal/from State Chesapeake Crem. 8/11/2010 Beltsville, Md 4 Donation 5 Other (Specify) PHILIP D.RINALDI FUNERAL SERVICE, P.A. neral Service 21. Signature of 9241 Columbia Blvd.Silver Spring,Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final v terio scherofic Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Tuesto for este do insequence offi To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to be detailed 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed this certificate 1 Yes 2 No Yes 2 N of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇛ 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred __ Natural 5 Pending Division home Fell UNKM 2 Accident 1 🗌 Yes 2 X No within 24 hours after death to the Funeral Director: A completed filled in by the t Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Sity or, Town, State) DA KK Homie pley Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the callse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Bay, Year)

se of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 | 0 27036 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Helen Morrison Sumpter 6:00 August ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1098 Bainbridge Road Cecil Port Deposit 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Jan. 9. 1925 Maryland **Director** 212-22-9372 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show idiral Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Cecil Maryland Port Deposit 1 Yes 2 No ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1098 Bainbridge Road 21904 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force 1 ☐ Yes 2 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Maryland Department of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Sergeant Key Bridge <u>Eleven Years</u> Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Sadie Linton 17. Father's Name (First, Middle, Last) Philip S. Morrison 19a. Informant's Name/Relationship (Type, Print) 1 and 2 show of Health and fitem 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ralph Sumpter (husband) 1098 Bainbridge Road, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or ot West Nottingham 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/18/10 Colora, Maryland 4 Donation 5 Other (Specify) Cemetery Signarare of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, iom cas Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Corebral Vasal Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertenanon 1 Yes 2 No 3 Probably 4 Unknown Dementin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 🗓 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🂢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at wo<u>rk</u>? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 29b. Signature and title of certifie 29c. License number DO044373 8/16 weidner 2016 F. MD address of person who completed cause of death (Item 23a) (Type, Print) Joseph K. Weidner. Jr., M.D., 101 Colonial Way; Rising Sun, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene.

			For State Registrar	State of Maryla		ertificate of D			Reg. No	2010	27037
ı	Physicia		Decedent's Name (First, Middle, Last JULIA) SEIP	P			2. Date of De Month	ath Da		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or l	Location of Death	August		c. County of Deat	
ا المعلومين ما	Funeral		Frederick Memor 5. Social Security Number 6. Se	rial Hospital	s. last birthday	Frederi	CK If Under 24 Hrs.	8. Date of Bin	th	Frederi	CK thplace (State or Foreign
	Director		215-20-2979 1 1 Dsual Residence of Decedent	^{□ M 2} X ^F 85	Yrs.	Months Days	Hours Min.	Oct. 1	y, Year) I, I	924 Man	ryland
	land show dat	tor	10a. State 10b. County	10c. (City, Town or I	_ocation					10d. Inside City Limits
	Mary 28a-f	irec	Maryland Montgom	ery	Dar	mascus					1 ☐ Yes 2 🔀 No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 28514 Kemptown	Road		10f. Zip Code 2087	7.2			itizen of What Co	ountry?
	items		11. Marital Status	12. Was Decedent Ever in I	U.S. 13	Was Decedent of His If Yes, specify Cuban		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
036	s after ral", or Exami	ed by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates,		1 ☐ Yes 2 🗓 No		, , , , , ,		Specify: Wh:	
5-0 -0	72 hour r "natu edical	Completed	15. Decedent's Ed (Specify only highest grad		(Giv	edent's Usual Occupat e kind of work done du	tion uring most of work	ing		Kind of Business	Industry
21215-0036	within 7 giene. er than		Elementary/Seconday (0-12)	College (1-4 or 5+)		DO NOT use retired) d Service W	Vorker			ool Sys	-
Maryland	ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				
aryi	nd Mer nd Mer s mark umatic	5	Ado1phus Clay 19a. Informant's Name/Relationship (Type	pe, Print)	19b. Ma	iling Address (Street an			atki er. City oi		o Code)
Σ	nd 2 sl ealth a m 27 is		John L. Seipp - 1		285	514 Kemptov					
nore	age 1 a int of H t: If ite / or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 C	Removal from State	cemetery, cr	position (Name of ematory or other place,)	Date		ocation - City or	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 tonation 5 Other (Specify, 21. Signature of F. neral Service License			ty Lutherar 22. Name and Address	of Facility	2010			er, Maryland
n	e a m e e	-/-	23a. Part 1. Enter the disease, or comp	Nelliam		Molesworth					
par 16	Physician/		shock, or heart failure. List only on Immediate Cause (Final	e caus on each line.		nter the mode of dying;	esuch as cardiac d	or respiratory an	rest,	,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		r					
		ner	Sequentially list conditions, if any, reading to immediate	o. Sue to (or as a conse	Shoc equence of):	i k					
	cuted and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a conse	renal	failure) 5				
-	s be exersician a burial-	ledical E	resulting in death) Last	- Hyperka		G					
09/90	tificate ing phy	Med	IF FEMALE:	7'							
POX 0	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ For 4 ☐ Pregnant at time of	etal death 3	☐ Ectopic pregnancy ☐ Other (specify)			1	23d. Date of del Month	livery Day Year
7. O. B	t the de by the tached	Physi	1 Yes 2 No 9 Unknown	g 🗌 Unknown		., ,,					
ν, Γ.	res tha signed d be de	Completed by Physician/N	Part II. Other significant conditions con Advenced de t	9	esulting in the	underlying cause give	n in Part I.				the cause of death?
Vital Records,	w requ is been 2 shouf	plete						24a. Was	an	24b. Were au	topsy findings available
ř	: The la	Com						autor perfo 1 Yes	rmed?	death?	s 2 🗆 No
Ita	rsician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	□ ER/Outpati	Lou	ce of Death (Check		danas 6	3 ☐ Other (Spec	ie a
10 1	ding Phy th. After this funeral o		27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time injury	of 28c. Injury a work?		28d. Describe h			117)
DIVISION OF	or Atten after deal Director: in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec			00 2 110	28f. Location (S City or Tow			ral Route Number,
ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examin	cian: To the best of my kno er: On the basis of examinat	tion and/or inve	estigation, in my opinion	, death occurred at	the time, date a	nd place	e, and due to the	cause(s) and manner stated.
	To the within To the comple		only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of	my knowledge	e, death occurred at the f				s) and manner as te signed (Month	
			An Co	MD			183			8/11/2	2010
	5		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, 7 <i>4</i> 6	troof. Fr	podemilo	, KAI) 2	1701	
	Stat Registra	-	31. Date filed (Month, Day, Year)	mpleted cause of death (Ite 32. Registrar's Sign 2010	nature	Market	- COUNT			- 1	
			nvu ± /	TOTAL ASSESSMENT	THE T	Section was an					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:30PM Month **Physician** JULIA BARBARA BAWGUS SEAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Plata Medical Charles Center a 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** JERSEY 1 - M XX Months Days Hours 212-44-7144 65 NEW Director 02-05-1945 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD CHARLES HUGHESVILLE Director 1 □ Yes XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7330 DAN BERNICE PLACE 20637 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☐ Xio Specify: Specify: WHITE Pages 1 and 2 should be filed within 72 hours onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", onenter than "natura 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL HISTOLOGIST 12TH YEARS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM ALBERT BAWGUS permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic examplingury or other traumatic examples. ANNIE HOPSON BAWGUS ၉ 19a. Informant's Name/Relationship (Type. Print)
MARY T. VITTUM/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7330 DAN BERNICE PL., HUGHESVILLE, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place)
TRINITY MEMORIAL
GARDENS CEMETERY Method of Disposition 20c. Location - City or Town, State AUGUST 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State WALDORF, MD 4 Donation 5 Dother (Specify) 18, 2010 21. Signature of Funeral Service Licensee #M00993 22. Name and Address of Facility
TERRENCE L. JOHNSON FUNERAL SERVICE
4433 WHITE PLAINS LN., WHITE PLAINS, TERRENCE L. JOHNSON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (o Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but Iting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 □ Yes 2 □ No 3 □ Probably 🕰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 □Yes 2 □No 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number 3BM 3 Center 70 Post Office Rd Waldorf, MD 20602 State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Lydia Shewbridge Lane P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico Wicomico Nursing Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🕱 F Days 225-01-5445 0873171921 **Director** Virginia 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 306 Brewington Drive 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 Midowed 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) administrative secretary education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilmour M. Will Lena Frank 19a. Informant's Name/Relationship (Type, Print)
Diane Shaff/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5419 St. Andrews Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brownsville Cemetery! 8/17/2010 Brownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ

Physician/ Medical **Examiner**

Baltímore, Maryland 21215-0036

shov

as

physician a the burial. filled in by

Division of Vital Records, P.O. Box 68760

Medical

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital of within 24 hours at To the Funeral Discompleted filled in State Registrar

Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my kinewisdige, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

29c. License number

29d. Date signed (Month, Day, Year)

Mahesha Thimmarayappa M.D. 910 Easternshore Dr Salisbury MD 21804 31. Date filed (Month 1967, Year) 3 2010

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	tate of Ma	aryland	-				/lental Hyg	0	010	270	LN
			State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death								010	3. Time of		
Phys			Chiyomi Takemoto							Month 8	Day 12	2010	7:00	РМ
	edica mine		4a. Facility Name (if not institution, give street	and number)			4b. City, Tov	vn, or Loca	ation of Death		1	ounty of Death	1,,,,,,,	
/			Montgomery General H	ospital			Olney	,			Mon	tgomery	7	
Fune	eral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Under 1 \ Months D		Jnder 24 Hrs. ours Min.	8. Date of Birth	Year)	9. Birth	olace (State or	r Foreign
Direc	tor	-	575-26-1732	2 24	80	Yrs.				12/22/1	929		Hawai	<u>i</u>
nd how	4	. I	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation					-	0d. Inside Cit	ty Limits
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or 28		Funeral Director	10e. Street and Number		COI	anora_	10f. Zip Co	ode			10g. Citize	n of What Cou	ntry?	
with s 23a	T Sn	era	6500 Freetown Rd.				2104	4			USA			
death				Vas Decedent E Armed Forces?	ver in U.S	. 13. W	as Decedent Yes, specify	of Hispani Cuban, Me	ic Origin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
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X1X13-UU36 within 72 hours after giene. than "natural", o		Completed	3 🔀 Widowed 4 □ Divorced	ducation 16a, Decedent's Usual Occupation 16b, Kind of Bus								_	nese dustry	
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10/fe, Maryland 21/215-UU30 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show			19a. Informant's Name/Relationship (Type, PCliff Takemoto / Sor	,						al Route Number c, Colu				
and 2 Healti em 2		-	20a. Method of Disposition	1	20h Pi	ace of Dispos				Date Date		tion - City or To		
baltimore, permit. Page 1 and 3 Department of Healt Important. If item 2		-1	1 Burial 2 Cremation 3 Rem	oval from State	Ce	emetery, crem	atory or othe	r place)	İ			•		
nit. Pa artme ortan	in a	H	21. Signal r o uneral ice Licensee	4 Donation 5 Other (Specify) Ardent Cremation 8/14/2010 Hanov Signal r of uneral lice Licensee M01411 22. Name and Address of Facility Harry H. Witzke										INC.
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Medi	cal		resulting in death)					, 1	1/4	./	1.0			
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certific anding		١٩	zob. Was decedent pregnant	f yes, outcome	of pregnar	ncy	Ectopic preg	anancy			230	d. Date of deliv	ery	-
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DIVISION OT VITAI RECORDS, F.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director page 2 should be detached for use as the build-transit		Medical	29a. Certifier 1 ★ Certifying Physician (Check 2 ★ Medical Examiner:	on the basis of ex	kamination	and/or investi	gation, in my	opinion, de	eath occurred a	t the time, date a	nd place, ar	nd due to the ca	iuse(s) and ma	nner stated.
o the lithin 2 the l			only one) 3 Certifying Nurse Pra	ctioner: To the	best of my	knowledge, d	eath occurred	cense num	e, date and pla	ce, and due to the	e cause(s) a	nd manner as s signed (Month,	tated.	
# 3 H 5			290. Signature and title of defittier	m			1			15				110
		-	30. Name and address of person who compl		eath (Item	23a) (Type. P								
5		- 1	Dr R Larkin, 1810	1 Princ	e Ph:	ilip D	r., Ol:	ney,	MD 208	32				
	State	2	31. Date filed (Month, Day, Year) AUG 1 6 2010	32. Registra	ır's Signati	ure								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician AM 2010 7:11 August Janie E. Upchurch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Princess Anne Somerset Manokin Manor Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 9-8-1906 Director 103 MD 196-26-2847 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City, Town or Location Pages 1 end 2 should be filed within 72 hours after death with the Marylan nent of Heelth and Mentel Hygiene.
ant: If Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow ury or other treumatic event, the Medical Examinating the inclined at 1 ☐ Yes 2√2 No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11464 Beckford 21853 Completed by Funeral Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐**N**o tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyBlack 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Hetzer Family Domestic Unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward S. Handy Janie Deshields 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29712 Steinhauer Street, Inkster MI 48141 Date 20c. Location - City or Town, State Robert Handy/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Denation 5 Other (Specify) permit. Page Depertment of Important: If eny Injury or once. John Wesley Cem 8-14-2010 Princess Anne, MD 2 Signature of Funerat Service Licenses 22. Name and Address of Facility 17 W. Isabella Street Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No certificete 1 Yes or Attending Physician: After this certification, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours efter deeth To the Funeral Director: filled in by Medical

State

NATESAN 31. Date filed (Month, Day, Year) AUG 13 2010

Nulsa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

5. DIVISION STELL 1415 32. Registrar's Signature

SALISBURY

21804

29d. Date signed (Month, Day, Year)

8/13/10

Registrar

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Xav Vo August 11, 1:40 a М Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min County) Vietnam Dec. 31, Year 1930 212-47-2468 79 Director Usual Residence of Decedent shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 No Maryland Mon topomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 8530 11th Avenue 20903 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc β 1 Never Married XX Married Maryland 21215-0036 Asian If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important If frem 27 is marked other than "na any injury or other traumatic event." 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer Vietnamese Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Day Van Vo Kim Phung Tran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8530 11th Avenue, Silver Spring, MD 20903 Le Ha Nguyen/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 15 August Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euperal Service Licens Francis J. down inc. 500 University Blvd. W., Silver Spring, MD 20901 Hry Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bilateral Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events brondriectas and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No the a | Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🖳 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital
within 24 hours a
To the Funeral C Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 220 wadi mD D68005 August 12th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue Takoma Park, mo 20912 Donadi mDI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

13

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			1 - For State Registrar		-		of Death		Reg. No.	27043		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Yea			
	/Media	al	Woodrow J. Vin			4h Cib. To	wn, or Location of Dea	08	06 2010			
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	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthd	y) If Under 1	Year If Under 24 Hr. Days Hours Mir			Birthplace (State or Foreign Country)		
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	/land		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
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	or 28	Director	10e. Street and Number			10f. Zip C	ode		10g. Citizen of What	Country?		
	ss 23s	Funeral	22682 Royal Oak	Road 12. Was Decedent E	vor in II S	218			USA 14 Bace A	nerican Indian,		
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	T E E	-	Deborah Vincent, 20a. Method of Disposition	/Daughte	20h Blace of Di	82 ROY sposition (Name	al Oak Ro	Date Quan	tico, MD 20c. Location - City	21856 or Town, State		
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Baltimore,	permit. Page Depertment Importent: if eny injury o		21. Signature of Furieral Service License						sabella S			
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Sp	13.44		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Finaf	e cause on each line	tne death. Do not	enter the mode	or dying, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death		
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X Q	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Petal death	3 □Ectopic preg			23d. Date of of Month	delivery Day Year		
o.	that the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	me or death	5 Other (spec	ту)					
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	To the Hospital or At within 24 hours effer or To the Funeral Directompletely filted in by		29a. Certifier 1 Certifying Phys	ician: To the best o	my knowledge, d	eath occurred at	the time, date and place	ce, and due to the	cause(s) and manner	as stated.		
	Vithin 24	Medical	one) 2 Medical Examir	and manner stat	examination and/o	r investigation, in	my opinion, death occ	curred at the time	, date and place, and o	lue to the cause(s)		
	To To	2	29b. Signature and title of certifier	1/1	40.0	29c. I	icense number		29d. Date signed (Mo			
	6		30. Name and address of person who co	moleted sauss of de	ath (Item 22a) (T	De Print)	1165		8-13-	10		
_	en		830 Chesa	people	Drive	Canh	oridge	MS	21613			
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		•	For State Registrar	State of Marylan Item 25 per me	nd / Dep , g906 <i>Ce</i>	oartment of 1 08/27/20 ortificate of L	lealth and M Death	ental Hy	giene Reg. No.	010	27044		
•	Physicia Medic		1. Decedent's Name (First, Middle, La CHARLES LET				ŀ	2. Date of De AUGUST		2010 ^{Year}	3. Time of Death 12:20P M		
	Examir		4a. Facility Name (if not institution, giv FREDERICK MEMOR			4b. City, Town, or FREDER	r Location of Death			ounty of Death			
	Funeral Director		227 22 0007	Sex 1 1 X M 2 1 F 89	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird May 21	h , Year 192	9. Birth Mary	pplace (State or Foreign nty) Land		
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi		y, Town or L ederic						10d. Inside City Limits X 1 ☐ Yes 2 ☐ No		
	vith the Ma 23a or 28 st be noti	eral Dire	10e. Street and Number 2406 Dominion Dr	ive, Unit 1D		10f. Zip Code 21702			_	en of What Cou			
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14	i. Race - Ameri Black, White, pec <i>ify:</i> Whi	etc.		
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	d 2 should alth and M 27 is mar ir traumati		19a. Informant's Name/Relationship (I	Type, Print) Tarner, wife	19b. Mail 2406	ing Address (Street a Dominion	and Number or Rural n Drive, 1	Route Numbe D, Free	r, City or To deric	wn, State, Zip k, MD 2	21 7 02		
Baltimore,	Page 1 and nent of Hex ant: If item ary or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Place of Disp emetery, cre unt 0	osition (Name of matory or other place Livet Ceme	etery Aug.	11, 2	20c. Loca	ation - City or T Frederi			
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and the	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	one dause on each line.	h. Do not en		g, such as cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death		
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_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 L Medical Exam	rsician: To the best of my knowle niner: On the basis of examination se Practioner: To the best of my	and/or inves	stigation, in my opinic	on, death occurred at t	he time, date a	nd place, ar	nd due to the ca	use(s) and manner stated.		
	To the community of the		29b. Signature and title of certifier	- M.D.		29c. License				signed (Month,			
			30. Name and address of person who	completed cause of death (Item			U)3		Augus	t 6, 20	OTO .		
	10		Shawn T Evans 31. Date filed (Month, Day, Year)			rick, Md.	21701						
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Signature State	l loss			Brenda Joyce At	kinson							29,	2010		Ам
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The composition of the control of				214 56 9386							n. (Month, Da	ıy, Year)	Cou	intry)	or Foreign
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Compared to the compared to	ary	shoul and Mi marl	۴	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	g Address (St	reet and i	Number or	Rural Route Numb	er, City or T	own, State, Zi	ip Code)	
Compared to the compared to		and 2		Anthony A. Atkir	nson (Son)		1	-		Balt	imore, Ma	arylan	d 2122	0	
Physician (Medical Examiner) 22. 28. Pint First the disease; or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, plant and the more of the cause of the c	ore	00		·	3 □Removal from S	tate 20b. F	Place of Dispo cemetery, crei	sition (Name o natory or other	of r place)	0.10			,	·	
Physician (Medical Examiner) 22. 28. Pint First the disease; or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, plant and the more of the cause of the c	tim	t. Pac rtmen rtant: rjury		4 □ Donation 5 □ Other (Sp	necify)	Bay							more,	Maryiai	11CL
Physician (Medical Examiner) To graph of the part of	Bal	Depa Impo any ir once		21. Signature of Funeral Service L	21. Signature of Funeral Service Licensee Service Licensee									nd 212	21
Physician (Medical Examiner) The proposed of the second properties of				shock, or heart failure. List of	complications that can only one cause on ea	used the deatl ch line.	h. Do not ent	er the mode of	f dying, su	uch as card	iac or respiratory a	rrest,		Interval Bet	tween
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The past 12 months of death of the past 12 months? Special Content of the past 12 months? Control of the past 12 months? Cont			Jer	Sequentially list conditions, if any, leading to immediate		r as a conseq	uence of):								
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 view 2 view 1 view 1 view 2 view 1	60,	be exectan a	E	resulting in death) Last	Due to (o	r as a conseq	uence of):								
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25. Was case referred to medical examiner? Second Continuous Co	Box	he death certif the attending thed for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1□Live bir 4□Pregna	th 2□Feta nt at time of d	Ideath 3					230		-	Year
25. Was case referred to medical examiner? Second Continuous Co	Δ.	ss that t gned by e detac		Part II. Other significant conditio	ns contributing to dea	ith but not res	ulting in the u	nderlying caus	e given in	Part I.	23e. Did	tobacco use	contribute to	the cause of	death?
25. Was case referred to medical examiner? Second Continuous Co	ord	require sen signould b									_ 132	Yes 2□	No 3∏Pro	obably 4 📑	Unknown
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Solution Street and Number or Rural Route Number, Street and N	0	Phys this ral dii		1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence										city)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and viting certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	lon	th. :: Afte	tion	1 X Natural 5 □ Pending (Month, Day Year) Injury Work?											
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and viting certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	Divis	or Atter after dea Director in by the	ertifica	3 Suicide 6 Could n	ned 28e. Place o			eet, factory, of	fice				Number or Ru	ral Route Nur	mber,
110057173 8/30/2010 Name and look ss of person who completed cause of death (Item 23a) (Type, Print) HUZEFA BAHRAIN NAME AND STE 314 BALTO, MD 21237	_	Hospital 24 hours: Funeral tely filled		(Check only 2 Medical E	examiner: On the bas	sis of examina									s)
110057173 8/30/2010 Name and look ss of person who completed cause of death (Item 23a) (Type, Print) HUZEFA BAHRAIN NAME AND STE 314 BALTO, MD 21237		o the	Mec	//	and manne	er stateu.		29c. Li	cense nui	mber		29d. Date	signed (Monti	n, Day, Year)	
O Name and Roless of person who completed cause of death (Item 23a) (Type, Print) HUZEFA BAHRAIN ON DELPHIA RD STE 314 BOUTD, MD 21237		->=0		///				HO	057	1173		8/3	0/2010		
State Registrar 31. Date filed (Month, Day, Year) 82. Registrar's Signature 84. Registrar		lov		0. Name and look ss of person v	who completed cause	of death (Item	n 23a) (Type,	Print) HUZE	FA B	AHRA	137	- 1	0=0		
					10 S2. Re	gistrar's Signe	ature	ed.	• 17	0-10					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 7:15 Tinderson Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Place Himore Assisted 5. Social Security Number 215-32-3664 7. Age (In yrs. last binhday) Yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State **Funeral** 1 □ M 2 ▼F Months Hours Min. Director 10c. City Town or Location 10d. Inside City Limits or 28a-f shov 10b. County 10a. State injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 23a 12. Was Decedent Ever in U.S. Armed Forces?₁ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Laşt) ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of germetery, crematory or other place) 20a. Method of Disposition of Fun (a) Service License 22. Name and Addr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Inset and Death Immediate Cause (Final disease or condition Physician SEPSIS WECK Medical resulting in death) Due to (or as a consequence of) Examiner mon this gangrene Sequentially list conditions, if any, leading to immediate Examiner to (or consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Pars and burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by aneurysm, CAD 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♠No 26. Place of Death (Check only one) Hospital: မ 4 Nursing Home 5 Residence 6 Nother (Specify) 4 SSISTER LINK 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Holden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

Eastern

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 9:30 M AUGUST Mary Ellen Brock 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Baltimore City 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Days (Month, Day, Year) Ine 22, 1946 Months Hours Min. Maryland 64 Director 218-50-7075 June Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Tes 2XXNo Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States ō Hygiene. other than "natural", or items 23a Funeral 4931 Millers Station Road 21074 America Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: If Yes Give Specify: 3 Widowed 4XX Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien. Office Personnel Engineering permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Tumminello Marion Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Considine (Son) 3036 Monroe Street, Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remetery, crematory or other place) AII Faiths Crematory & Chapel 1 Burial 2XXCremation 3 Removal from State Aug. 30, 2010 4 Donation 5 Other (Specify) Manchester, Maryland 21/ Signature of Fundamic Lice Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death gastrointestina blee dius Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Emer Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cervical Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been si should I Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s Hospital or Attending Physician; The law autopsy performe 1 Yes 2 No Yes 2 **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certainly income the cause of provided the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and this of certifie RES-000 ress of person who completed cause of death (Item 23a) (Type, Print)

4 ASOMAITTE, MS S Sinai Hospital of Ballimore 30. Name and add 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BAILEY **JEAN** CLARA 6:15 August 2010 рМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE Arundel Annapolis Heart Homes Assisted Living 8. Date of Birth

(Month, Day, Year)

Jan. 22, 1931 Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Maryland Jan. 79 217-26-2364 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director South Baltimore Baltimore 1

Yes 2 □ No Maryland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ō 21230 Funeral 507 East Barney Street items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married "natural", or <u>Ş</u> Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary-Receptionist Home Safety Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Fultz John Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Raymond Avenue, Eldersburg, Maryland 21784 Paul Bailey (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Aug. 31, 2010 | Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun al Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ EMENTI ease or condition esulting in death) Medical Di to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Dusité (or es e consequence of): signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 ✓ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy death? 1 ☐ Yes 2 No Yes is eo Living 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After work? injury Matural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 3.0

Negl

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601 Veterans He

753

29d. Date signed (Month, Day, Year) August 25.

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:35 PM Ruth Maddox Bellamy August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Center for Hospice Care Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Sept. 26, 1926 Min. Director 215-20-3299 83 Maryland Usual Residence of Decedent show 10b. County 10a, State Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 28a-f 1 🛛 Yes 2 🗌 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a U.S.A. 7110 Minstral Way, Apt. 357 21045 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Maddox Helen L. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Bellamy/ son 10069 Shaker Dr., Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, injury or 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 8/24/2010 Sykesville, MD 21. Signature of Fineral Service Live 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mal montas Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) NOCOLY 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 23 2010

Registrar

State

6701

dress of person who completed cause of death (Item 23a) (Type, Print)

CHAR

2010

31. Date filed (Month, Day, Year

AUG 30

S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20:58 M 2010 RAYMOND BARNETT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltmore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Hours Min. Country) MARCH 14, 1914 NC Director 96 244-26-2417 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time ZT is an arted other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director PIKESVILLE 1X Yes 2 🗌 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3711 SEVEN MILE LANE 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. Baltimore, Maryland 21215-0036 Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. Specify: 3 Widowed 4 Divorced BI.ACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SWIFT CHEMICAL PLANT TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES BARNETT BARNETT SALLIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SEVEN MILE LANE BALTIMORE, MD MARGARET BARNETT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD NATIONAL MEM. PK. 9-2-2010 LAUREL, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 4 1701-31 LAURENS ST. BALTIMORE, MD 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Resolvatory DISTIES disease or condition Medical resulting in death) Examiner umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death☐ Unknown After this certificate has been signed by the a funeral director, page 2 should be detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, hyperlipidemia 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, n 24 hours after o determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ompleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

AUG 30

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle | ast) Month 16119 Day Physician/ Karen Yvonne Benson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth Aug 2, 1950 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 🕱 F Hours Maryland 212-67-6788 60 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number Funeral 21204 USA 1 Smeton Place; Unit 907 items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 9 1 Never Married 2 Married "natural", or Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) publications bookkeeper injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic and မ Goldie Sue Barker Donald Cameron Pople 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4139 Little Road; Whiteford, Maryland 21160 Charles Ronald White - brothe 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Foard . Sig ature of Inneral Service rector 655 W. Baltimore Street; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Other (specify) Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 X Yes 2 ☐ No performed? hours after death.

Ineral Director: After this certificate he filled in by the funeral director, page Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certificate: To 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examin 3 Certifying Nurse (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATHOLOGIST 08

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 3 0 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2.7 2010 Claude Clifton Cline 4:00 aM Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** XM 2□ F Months Days Hours 217-18-4445 86 Yrs Director June 2, 1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 1 ☐ Yes XX No Directo Maryland Carroll Manchester 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 3303 Lineboro Road 21102 America 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XNo 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 ☐ Yes ŽÍŽNo Specify þ Specify: 3€XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Jo<u>urneyman Plumber</u> Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clealand W. Cline, Sr. 2 Nellie E. Northcraft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelly G. Warren (Daughter) <u>3303 Lineboro Road, Manchester, Maryland 21102</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sep. Date 1, 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem'l Grdns 2010 Bel Air, Maryland re of Fun tal Salvice Licen 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD. 21102 ty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** atheroscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 Yes 2 ER/Outpatient ပ္ 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural

Box 68760, P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore,

physician attending properties for use as signed by t certificate has To the Hospital or Attending Physician: this After this funeral d hours after death within 24 hours after death

To the Funeral Director:
completely filled in by the

State

Registrar

Medical

2 Accident

3 ☐ Suicide

4 Homicide

Manual Media (s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature, and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day Year) 10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

6 ☐ Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryland				and Men	tal Hygi	ene 2 n	10	27053
		Registrar Certificate of Death Reg. N							1 0	
Physici Medi		Decedent's Name (First, Middle, Last) Milton Edward Cheston				1	Date of Death Month	Day 2	Year	3. Time of Death O7:55 M
Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location o	of Death		4c. County of	of Death	
		Prince George's Hospital 5. Social Security Number 16. Sex 17. Age fin vrs. last		Chever1		0411 1		Princ		orge's
Funeral Director		242-28-6478 ¹ ♠ ² □ F 93	birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. (/ Au	Date of Birth Month, Day, Y	(ear) 1917	9. Birthp Count Nort	olace (State or Foreign try) h Carolina
how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	own or Loc	cation					1	0d. Inside City Limits
anylar la-fs	Director								- 1	1 Yes 2 No
the M or 28 e not		Maryaind Prince George's Upper 10e. Street and Number	mar.	10f. Zip Code		-	10	g. Citizen of W	hat Coun	
with 1 s 23a ust b	Funeral	703 Haack Place		20	774			U.S.A.		,
leath items er mi	F	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Orig	in? (Specify Y	es or No-	14. Race	- America	an Indian,
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced Armed Forces? 1 ※ Yes 2 ☐ No If Yes, Give Year or Dates.		Yes, specify Cubar		, Puerto Rican	, etc.)	Black Specify:	, White, e	
hours natur	ete	15. Decedent's Education		ent's Usual Occupa			11	6b. Kind of Bus		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life, DC	rind of work done d O NOT use retired)	uring most	of working				20.17
d with	BeC	11 17. Father's Name (First, Middle, Last)]	Farmer				Agricu.	<u>lture</u>	<u> </u>
land be filed ental Hy ked oth	<u> </u>	Joseph Cheston				,		iden Surname)		
Marylaı should be and Ment is marker raumatic e		Joseph Cheston Affire Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								Pada)
= "		Helen C. Bryant (Daughter)		gaddress (Street a Haack P1.				•		ode)
1 and 2 thealt litem 2 other		20a. Method of Disposition 20b. Plac	e of Dispos	sition (Name of		Date		0c. Location - 0		wn, State
Page Trent c ant: If		TEL Buildi E E Cicination o E ricinova nom otate		natory or other place netery		/4/201	$_{\text{I}}$	renton	. NC	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signiture of Juneral Service Licen ee	22. N	Name and Addres	s of Facility eral	Home,	Inc.			
		23a. Part 1. Enter the disease, or complications that caused the death. I							Blvc	Approximate NC
Pnysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		wanton	mn	a oth	~/			Interval Between Onset and Death
Medical		Immediate Cause (Final disease or condition resulting in death) a	ce of):	3-1 000	, 0	4-20-5	7		-	
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p #	Examiner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequent								
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cate be executed physician and the burial-transit	edical	L End 1+	,	2 seu	م ا ه	usee	00			
ficate be g physic		d								
X 68 n certific ending r use as	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1		Ectopic pregnancy	,			23d. Date	of delive	ry
BOX The death of the atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)				Mont	th	Day Year
that the ned by t	by Pr	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause glve	en in Part I.	. 2	3e. Did toba	cco use contrib	ute to the	e cause of death?
dS, quires en sign	ed b						1 🗆 Yes	2 A No 3	B 🗌 Prob	ably 4 🗌 Unknown
VITAI KECOTAS, ysician: The law requires s certificate has been sig director, page 2 should b	Completed						24a. Was an autopsy			sy findings available npletion of cause of
The la	Con						performe	d? de	eath?	
cian: cian: ertific	Be	25. Was case referred to medical examiner?				(Check only	one)			
T VI	은	1 Inpatient 2 ER	Outpatient		4 ∐ Nur			ce 6 🗆 Other		
nding Pr nding Pr th. After th funeral	Certificate:	1 Natural 5 Pending (Month, Day, Year)	injury	28c. Injury work? M 1 🗆	at Yes 2□1	1	escribe how	injury occurred	f	
DIVISION al or Attendin s after death. al Director: Aft ed in by the fur	E I	3 Suicide 6 Could not be 28e. Place of Injury - At home	, farm, stree		700 2 2 1		ocation (Stree	et and Number	or Rural I	Route Number,
ital or Irs after al Din		building, etc. (Specify)				С	ity or Town, S	State)		
DIVISION OF VITAL RECORDS, P.O. BOX 68/7 To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check conly one) 1 ★ Certifying Physician: To the best of my knowledge to the basis of examination and the conly one) 2 ★ Medical Examiner: On the basis of examination and the basis of examination ana	d/or investig	gation, in my opinior	n, death occ	curred at the tir	ne, date and p	place, and due t	o the caus	se(s) and manner stated.
To t		29b. Signature and title of certifier wool elly ,		29c. License	number	189		I. Date signed (ay, Year)
U		30. Name and address of person who completed cause of death (Item 23)			Hospit	tal Dri	Lve, Cl	neverly	, MD	
Sta Registra		31. Date filed (Month, Day, Year) AUG 3 0 2010 32. Registrar's Signature								
		nou ou colo persono p.	arre							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MARGUERITE CARTER August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNION MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year, Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🔽 F Director 68 2-12-1941 220-38-5302 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director N/ABALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 815 WINTERS LANE APT 318 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married Ď Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: BLACK Completed 3 √ Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) UNIVERSITY OF MARYLAND FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ IRVIN HARCUM NANNIE HARCUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARTER (SON) 1035 N. KENWOOD AVE. BALTIMORE, MARYLAND 21205 WILLIAM 20a. Method of Disp 1 Burial 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 3 Removal from State 4 Donati Other (Specify) ARBUTUS MEMORIAL PARK 8-28-2010 BALTIMORE, MARYLAND License ONATHAN HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Preumonia Medical Due to (or as a consequence of) Examiner metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (oras a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Renal Cell Carcinoma Due to (or as a consequence of): attending physician for use as the buria Chronic Obstructive Pulmonary Disesse Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 No Be 25. Was case referred to medical of Vital director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred Hospital or Attending 5 Pending Division 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certifie ess of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

g. Birthplace (State or Foreign

10d. Inside City Limits

Approximate

Onset and Death

Year

Day

2 No

1 X Yes 2 No

MARYLAND

10:35 PM

Year

2010

Black, White, etc.

Month

death?

State Registrar 31. Date filed (Month, Day, Year)

CYFBI-FOSTTR, MD Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Month rawfor 0230 an 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1MM N/A BAITIMOre 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Min. 56 Hours Ma(M95th, 1954ar) Florida 174-48-7149 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified the once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pennsylvania Delaware Chadds Ford 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 19317 USA 12 Hilloch Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 KNo Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Title Insurance Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William C. Crawford Barbara Covner 19a. Informant's Name/Relationship (Type, Print)

Cynthia Crawford/ Wife 19b, Mailing Address (Street and Number or Rural Rgute Number, City or Town, State, Zio Code)
12 Hilloch Lane Chaods Ford, Pennsylvania 1931/ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8/28/10 Upper Darby Pennsylvania Funeral Home 22. Name and Address of Facility Leonard J. Ruck, Inc. . Signature pt Funeral Service Licensee 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ archac disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** emi Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) DN Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 4a End disease this certificate 2 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other |2 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 1 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESDO

DHMH 17 Rev 7/2009

State

Registrar

UMMC

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYKIE

AUG 3 0 2010

MIL

32. Registrar's Signature

Knownes, Theodore Coles Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month EODO RE 2: 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Sinai Hospital 5. Social Security Numberunk If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) 87 If Under 1 Year 9. Birthplace (State or Foreign Country) Hours Min Sept 10, 1 X M 2 D F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 5015 Sunset Avenue 12. Was Decedent Ever in U.S. Armed Forces?unk
1 ☐ Yes 2 ☐ No
If Yes, Give 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business IndustryUn (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) unk College (1-4 or 5+)
unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \overline{unk} 19a. Informant's Name/Relationship (Type, Print) Ann Garrison - caregiver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State cemetery, crematory or other place) Signatur Funer Service Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine 0 the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform death? Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. 821 N-Eutew 1AQ

State

Registrar

31. Date filed (Month, Day, Year)
AUG 30

2010

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 9, **Physician** 2010 8:12 AMM Herman E. Callis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 12 Cutlass Drive Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Mary I and 1⊠ M 2□ F Yrs. 217-20-6511 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or items 23a or 28e-4-100cs. 10a. State 10c. City, Town or Location 10d. Inside City Limits Berlin 1 ☐ Yes 2 No **Funeral Director** MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12 Cutlass Drive 21811 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) condominiums manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Callis Loretta Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Cutlass Drive; Berlin, Maryland 21811 Barbara Casllis - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑Donation 5☐Other (Specify) 22. Name and Address of Facility State Anatomy Board ector 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. In ter the disease, or com/lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o Vieart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Canel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompletely filled in by the funeral director, page 2 should be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 4 Nursing Home Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 🗌 No 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Box 68760

P.O.

Division of Vital Records.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST Andrea Campos 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Unk **Funeral** 6. Sex 8. Date of Birth Days Min. July 23, Year 941 1 □ M 2 🗓 F 69 220-36-1438 Director Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location Director Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 Funeral 1 Buttrick Court; Apt 303 Was Decedent Ever in U.S Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk 1 □ Never Married 2 □ Married Black, White, etc. ð Yes Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 XNo Specify: If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 111 k ٩ 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7601 Osler Drive; Towson, Maryland 21204 St. Joseph Medical Center 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from cemetery, crematory or other place, 4 ☐ Donation 5 ☑ Other (Specify) in state. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ceart failure. List only one cause on each line. Immediate Cause Final disease or condition Physician/ ACUTE MYOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE RENAL FAILURE Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ANOXIC ENCEPHALOPATHY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No death? 1 Yes 2 No **Division of Vital** æ 2 Certificate:

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s

5. Was case referred to medical	_ 2	6. Place of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)
7. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year) injury	njury at work? 28d. Describe how injury occurred work?
3 ☐ Suicide 6 ☐ Could not to determined		ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	niner: On the basis of examination and/or investigation, in my	time, date and place, and due to the cause(s) and manner as stated. pinion, death occurred at the time, date and place, and due to the cause(s) and manner state the displaced to the cause(s).

29c. License number

D 30263

1:40 PM

10d. Inside City Limits

Onset and Death

Day

29d. Date signed (Month, Day, Year)

8-15-10

1 🗆 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS TAT-TEE KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

Medical

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:30 AM OU Christenser 2010 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Feb 28, Director 550-38-4796 79 1931 California Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Calvert St. Leonard 1 ☐ Yes 2√ No Director 10f. Zip Code 20685 10g. Citizen of What Country? 10e. Street and Number 1035 Picture Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unit 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wiley Fountain Crockett Corinne Julia Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Carroll - son 1035 Picture Drive; St. Leonard, Maryland 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) ure of yright Con 22 Name and Address of Facility State Anatomy Board 21. Signa 655 W. Baltimore Street; Baltimore, MD 21201 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nrovic /Medical Due to (or as a consequence of): Examiner failure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed physician and s the bunial-trans Hyperten Box 68760, Physician/Medical multiple as attending IF FEMALE nse yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or VItal Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No r 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calvert County Nursing Center

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

AUG 30

32. Registrar's

Prince Frederick ,MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Mertificate of Death		ene .N2010 27060
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
~	/Medic		Betty Jane Chaney		August 1	4, 2010 9:55 AM M
	Examin	er	4a. Facility Name (If not institution, give street and number) 701 E. 4th Street	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cumberland () If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Allegany 9. Birthplace (State or Foreign
	Director		218-12-5835 ^{1 M} 2 M F 87 Yrs.	Months Days Hours Min.	Dec 12, 1	922 Maryland
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	Maryl -f sho	tor	MD Allegany Cumber			1 ☐ Yes 2% No
	with the 3a or 28a	I Director	10e. Street and Number 701 E. 4th Street	10f. Zip Code 21502	10g	Citizen of What Country?
5-0036	J within 72 hours after death with the Maryland glene. The Marker of thems 23a or 28a-f show the Marker of the meiffled at the Marker routh by meiffled at	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? ⟨Spe If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
ည် က	72 ho	sted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16	b. Kind of Business/Industry
2	within intention in the within	Completed	Lieinerkary/Secondary (0-12) College (1-40) 5+)	e kind of work done during most of workii DO NOT use retired)	ng	C 1 1 1
7	e filed wall Hygie other the		17. Father's Name (First, Middle, Last)	ashier	(C)-1 18/4/1- 18-1	food industry
yland	~ = 0 2	To Be	Leo Chaney		(First, Middle, Mai Elizabet	h Platters
Mar	12 sh th and 7 is rr traurr			ling Address (Street and Number or Rura		
ص ر	Heall Heall tem 2			5 Green Forest Dr;		ennsylvania 15505 Location - City or Town, State
aitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		4 Donation 5 Other (Specify)	ematory or other place)		
ga	permi Depar Impor any Ir	y j	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sta 655 W. Baltimore		altimore, MD 21201
ji gr	Physician /Medical Examiner	Examiner	23a. Part Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line. Immediate Cause final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	liastolic Congesti	ir respiratory arrest	Approximate Interval Between Onset and Death Few days Few days Few days
J. DOX 00/00,	ath certificate be ttending physicis or use as the bur	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
-	res that the de signed by the a be detached f		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underhibe asses there is Deat I	20a Didasha	co use contribute to the cause of death?
, and	n signe	d by	Pamaytopena, advance		1 ☐ Yes	2 No 3 Probably 4 Unknown
3	as been s 2 should	olete		0	24a. Was an	24b. Were autopsy findings available
ושו ה	ician: The la certificate ha ector, page 2	e Completed	25. Was case referred to medical		autopsy performed 1 ☐ Yes 2	prior to completion of cause of death?
5	rnysician: rrthis certific ral director, I	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ont 3 DOA Other:	r-	e 6 ☐ Other (Specify)
5	naing Pn uth. :: After th e funeral		27. Manner of D ath Matural 5 Pending 28a. Date of Injury 28b. Time 28b. Accident 28b. Time 28b.	,	28d. Pescribe how i	
	of the nospital of Attendant within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
1	e nospin 124 hours e Funera letely fille	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a ovestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
ř	withir To th comp		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			I thua Scaled MD	D-46346	•	8/17/10
7			30. Name and address of person who completed cause of death (Item 23a) (Type	·		,
	Clas		Huma Shakil 625 Kent Ave. #204 31. Date filed (Month, Day, Year) 32. Registrar's Synhature		2-3754	
	Stat Registra	-	AUG 30 2010 June 18. par			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 18 2010 6:30 A^{M} Diann Emily Churchill 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick 1100 Peach Orchard Lane #115 Brunswick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1 □ M 2 🗓 F Months Days Hours Sept 6, 219-46-2234 65 1944 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location Frederick Brunswick 1 ☐ Yes 2 ☐ No 10f. Zip Code 21716 10e. Street and Number 10g. Citizen of What Country? 1100 Peach Orchard Lane #115 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 至 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married white 1 ☐ Yes 21 No Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) counselor drug rehabilitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Thomas Butt Viola May Pearson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

John, m Dring Frederick Maryland

Physician /Medical For State Registrar

10a. State

MD

19a. Informant's Name/Relationship (Type. Print)

Director

Funeral

þ

Completed

Be

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Physician

/Medical

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Mydral Examble in the once.

Examiner physician and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

the signed by t certificate ha rector, page 2 director within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

ij	Ann Miller - dau	ghter	2439 01	d National	l Pike	#B3; Mi	ddletown	, MD 21769
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	1 00	ace of Disposition (Nametery, crematory or	nme of other place)	Date	20c.	Location - City or	Town, State
	21. Jignatura of Funeral Service License	Director		and Address of Facility			•	
	X 16001111	well	655	W. Baltime	ore St	treet; Ba	altimore,	, MD 21201
	23a. Part 1 Enter the disease, or compli- shock, or heart failure. List only on Immediate Cau Enal	e cause on each line.		1.65				Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a conseque		tive full	~~~	2-7 01	Jeele	1º years
_	Sequentially list conditions, if any, leading to immediate							
mine	Cause (Disease or injury	Due to (or as a conseque	ence of):				-	
Exa	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):					
ical	d	J.						
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic				23d. Date of de Month	livery Day Year
	Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying	cause given in Part I.				o the cause of death?
Completed by						24a. Was an autopsy performed	24b. Were at prior to death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?			26. Place	of Death (C	Check only one)		
0	1 Yes 2 No H	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 🗆 [OOA Other: 4 🗆 Nu	rsing Home	5 🗷 Residence	6 ☐ Other (Spe	ecify)
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	280	f. Describe how in	njury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, facto	ry, office	28f.	Location (Street City or Town, St		ural Route Number,
edical Certification:	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	d at the time, date an on, in my opinion, dea	d place, and th occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Ĭ	29b. Signature and title of certifier	Lerner O	n,0 2	9c. License number	9	- 1	Date signed (Moni	th, Day, Year)
3	30. Name and address of person who co	23a) (Type, Print)						

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 27062

Michael A. Coll State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) August 26, 2010 1500 hrs **Medical Examiner** Michael A. Coll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 95 North Mile Marker 57.2 Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 1 X M 2 F 36 02/28/1974 PA 194-68-3138 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State s 23a or 28a-f show e notified at once. 1 Yes 2 X No Dretel Hill PA Delaware with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36-12 Revere Road 19026 USA Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nothe Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? 2 X No Yes Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygione.
ant: If item 27 is marked other than "natural", o rother traumatic event, the Medical Examiner u 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No specify: Specify: White ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 2+Computer Technician Technical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Mathews Michael F.X. Coll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ 19a. Informant's Name/Relationship (Type, Print) 9 Michael Coll 3518 Beechwood Rd, Garnet Valley, PA 19060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 9/1/10 crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Delaware Co. Crem. Lansdowne, PΑ 4 Donation 5 Other Specify. 22. Name and Address of Facility The Doyle-Stonelake Funeral Home Harman of uneral Service Licenses 85 E. Baltimore Avenue, Lansdowne, PA 19050 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the 3 Ectopic pregnancy Month Year 1 Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 ned by the a 23e. Did tobacco use contribute to the cause of death? <u>o</u>. contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ğ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Aug 26, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification Subject witnessed stepping in front of semi-1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1406 hrs 1 Yes 2 V No Pending trailer truck on highway 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 95 North Mile Marker 57.2, Baltimore, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. August 27, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year

Physician Medic Examine Funeral Director per It. Page 1 and 2 should ce filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	Please Type or Pr				-	_	ole.							
	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2 1 1 2 7 1 6 3													
-		Cer	rtificate of L	<i>Death</i>		. No	0 2/063							
1/		as-Karabela	26		2. Date of Death Month August 2	Day 2010	3. Time of Death							
al er	4a. Facility Name (if not institution, give street and number)	as-naraber		Location of Death	August Z	4c. County of								
3 I	Frederick Villa		Catons			Baltir								
	5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign							
	177-12-8167 1 M 2 F Usual Residence of Decedent	90 Yrs.	World S Bays	Tiouis Iviii.	March 12	, 1920 _{Pe}	Country) ennsylvania							
ŏ	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits							
rect	Maryland Harford	Joppa	atowne				1 ☐ Yes 2 🔀 No							
	10e. Street and Number		10f. Zip Code		100	g. Citizen of Wha	Country?							
nera	626 Harborside Drive		21	085		USA								
豆	11. Marital Status 12. Was Decedent Armed Forces?	· I	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.							
d b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates.		White											
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	ness Industry												
duc	,													
Be	8 years	1ome												
To B	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Surname)								
	John Melonas													
	19a. Informant's Name/Relationship (Type, Print) John Karabelas son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2026 Daisy Avenue, Baltimore, Maryland													
	20a. Method of Disposition	20b. Place of Dispo	sition (Name of				ty or Town, State							
	1 □ Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Oak Lawn	natory or other place Cemetery	9 Septe 11 20		undalk,	Maryland							
	21 Signature of Funeral Service Licensee	22 CC	2. Name and Addres	s of Facility	me Of Dun Road, Dun	dalk D	λ							
- 11	Alla mel		10 Solle	rs Point	Road, Dun	dalk, Mo	1. 21222							
	23a rt 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	e.					Approximate Interval Between Onset and Death							
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a E	resulting in death) Last Due to (or as	a consequence of):												
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Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy				23d. Date of	of delivery							
icial	in the past 12 months? 1 ☐ Live Birth		Ectopic pregnanc Other (specify)	y 		Month	· ·							
hys	9 Unknown 9 Unknown				_									
by	Part II. Other significant conditions contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.			te to the cause of death?							
ted	ASTHMA				1 L Yes	2 □ No 3 l	Probably 4 11 Unknown							
Completed by					24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of							
3	25. Was case referred to medical				performed 1 Yes 2	- L	Yes 2 No							
lo Be	examiner? Hospital:	ient 2 ER/Outpatien	Othe	r: Check										
e:	27. Manner of Death 28a. Date of inju	ury 28b. Time of	28c. Injury	at 2	me 5 Residence 28d. Describe how i		Specify)							
ricai	2 Accident Investigation	y, Year) injury	M 1 □	Yes 2 No										
ert	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,							
cal	e etated													
Medical Certificate:	29a. Certifier (Check conly one) 3 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of each only one) 3 ☐ Certifying Nurse Practioner: To the	examination and/or invest	igation, in my opinio leath occurred at the	n, death occurred at time, date and plac	the time, date and p	lace, and due to	the cause(s) and manner stated.							
	29b. Signature and title of certifier		29c. License		29d.	Date signed (M	Ionth, Day, Year)							
	30. Name and address of person who completed cause of d	leath (Item 23a) (Type, P	rint) V			0 1 2 +	110							
	RODOLFO GERMAMOSE	MD 5161	v led ling	Rd Ste Zo	05 Catons	inlem	721268							
	31. Date filed (MorAUG 30 2010 32. Fgistr	ar's Signature	and											
			A											

State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2010 P^{M} Evelyn Dixon August 21 Bessie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Larkin Chase Nursing Home Rowie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday) Funeral Days Hours Min. Aug. 26, 1915 1 D M 2 X F North Carolina Director 077-22-4616 94 Yrs. Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Ty Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral 12018 Hunterton Street 20774 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner r Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced **Black** Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Staple Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ronald Davis Rose Lee Holley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Davis Willis (Niece) 12018 Hunterton St., Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 8-28-2010 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carolina Biblical Gardens Jamestown, NC 22. Name and Address of Facility
S.E. Thomas Funeral Service Signature of Funeral Septice Highland Ave., Thomasville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 🎇 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus autopsy performed? Yes 2 X No 1 🗌 Yes 1 Yes 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide after death

Director: A

I in by the f Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined Medical 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45217 August 23, 2010

State Registrar 6201 Greenbelt Road, Ste M18, College Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isaac Ajayi,

MD

32. Registrar's Signature

Adebowale

31. Date filed (Month, Day, Year)

AUG 30

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _28^{Day} Physician/ Price Davis 2010 Year Carlton August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia 6012 Misty Arch Run If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ₹ M 2 □ F 212-38-4168 70 Yrs 2940 Director Aug Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at Director Sykesville MD Carroll 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? USA Funeral 23a 21784 603 Trixsam Road . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

tant. If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction draftsman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cathryn A. Dougherty ၉ Charles H. Davis Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Trixsam Rd., Sykesville, MD 21784 Kenneth R. Davis (son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)

County Cremation 9-30-10 1 Burial 2 X Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Faige Haight P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlyin.
Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 2 A No 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Mann f Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate

Interval Between Onset and Death

Year

Day

2 No

1 ☐ Yes 2 🕅 No

7:15a

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS.G907,9/1/2010, wS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary W. Darr Aug. 24, Physician/ 2010 12:15 PM Darr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 24 1 🗆 M 2 🕱 F Months Days Hours Min. Pennsylvania Director 200-14-0057 86 Usual Residence of Decedent perrit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Degartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 💆 No Baltimore Towson Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 21286 USA 1405 Margarette Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ McMahon Wurdack Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2911 Superior Avenue Parkville, Maryland 21234 Clare D. White/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. Grd. 8/27/10 | Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or implications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one counter on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) THI Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence to the Funeral Director after this confidence. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ditch 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 1 Natural
2 Accident
3 Suicide 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W NS U N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Physician/ 10:45A™ DeRita 2010 Mary Aug Ann Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Manor Care Rossville Nursing Ctr. Rossville Baltimore Co If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Month, Day, Year) **Funeral** Days Hours Min. Country) 1 M 2 X F 217-24-1862 80 Maryland Director Nov. Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2363 Searles Road 21222 United States should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items aumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Crown Cork & Seal Co. Seamstress 7 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be.
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev 2 John Thomas Hutson Lillian Parlette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel J. DeRita Maryland (Husband) 2363 Searles Road Dundalk, Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 8/30/2010 4 Donation 5 Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition GENERAL Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine due to (or as a consuciones of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) ESOPHA GUS physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant at time of death g Unknown ed by the a detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed?

1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 08-26-2010

State Registrar

AUG 3 0 2010

BAYINOUNG.

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAYINOUNG WO 8022 BELALIZ ROAD 32. Registrar's Signature

NOTTINGHAM, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** S 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution) give street and number, Examiner 8. Date of Birth (Month, Day, Jan 4, Birthplace (State or Foreign Country) unk **Funeral** Social Security Number 7. Age (In yrs. last birthday Year) 1939 Months Days Hours Min. 1 ☑ M 2 ☐ F 215-40-5302 71 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore 12 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21206 USA 6116 Belair Road 23a Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces?unk 1 □Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 □ Never Married 2 □ Married 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ 3 Divorced 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation unix 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within Hygiene. marked other than Elementary/Secondary (0-12) unk College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6116 Belari Road; Baltimore, Maryland 21206 Narayana Wilson – social worker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify)in state 22. Name and Address of Facility State Anatomy Board L uneral Service lice rector 655 W. Baltimore Street; Baltimore, MD 21201 16 23a. Part 1. Inter the disease, or complications that caused the death. shock, or heart failure. List only one cause of neath lin. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of cardiac or respiratory arrest **Physician** /Medical lue to (or as a consequence of): Examiner nasi Sequentially list conditions, If any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed and burial Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No led by the Yes o 9 Unknown 9 Unknown ٣. The law requires that signed I eath but not resulting in the underlying cause given in Park ignificant conditions fontributing to 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: dire 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Nursing Home 5 Residence 6 Other (Specify) Certification: To this . Manyer of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ccident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

AUG 3 0 2010

31. Date filed (Month, Day,

2. Registrar's Signature

A. Aark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05745 State of Maryland / Department of Health and Mental Hygiene Randolph Dukes 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1812 hrs Medical Examiner Randolph Dukes July 31, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 1701 Eutaw Place, Apartment 619 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk If Under 1 Year Social Security Number unk6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Oct 4, 1948 Director 61 Country) $_{1}X_{M}$ 2___F Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 X Yes 2 No , or items 23a or 28a-f show r must be notified at once. Baltimore MD more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 1701 Eutaw Place #619 21217 USA Funeral 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S Armed Forces? unk White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 Yes If Yes, Give Year Yes 2 X No specify: Specify: black 3 Widowed 4 Divorced traumatic event, the Medical Examiner "natural", ş Dates 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical unk unk 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last)unk æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore City Police 601 E. Fayette Street; Baltimore, MD 21202 Baltimore, I permit. Pages 1 and 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in 22. Name and Address of Facility State Anatomy Board Signature of Fundal Service License naid S. Director 655 W. Baltimore Street; Baltimore, MD 21201 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Pan I. Enter the disease, or complications **Physician** Between Onset and failure List only one cause on each line (Martites Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED After this certificate has been signed by the attending physician of the all director, page 2 should be detached for use as the burial UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Certification:

To the Funeral Director: completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24

				1 Yes 2 ✓ No	1 Yes	2 No
5. Was case referred to medical			26.Place of Death (Check	only one)		
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursi	ng Home 5 Residence	6 🗸 Other: Scen	e
7. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury of	occurred	
1 Natural 5 Pending	(Month, Day,Year)		1 Yes 2 No			
2 Accident Investigat	tion	for the state of the state of		205 Leasting (Charat and I	North and an Division Design	uta Numbas Cit
Suicide 6 Could not	t be 28e. Place of Injury - At he	ome, tarm, street, tactor	y, office building, etc.	28f. Location (Street and I or Town, State)	Number of Rural Rol	ate Number, Ci
determine	ed (Specify)					

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and ifie of certifie -OCA

29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E. August 17, 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

29a. Certifier (Check only

Victor Weedn MD JD

Medical

egistrar's Signatur

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	State of Maryland / Department of Health and Mental Hygiene	_	U	1	U

Robert Eugene Durham Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 1 0 2 7 0 7 0							
Robert Eugene	Duri	State of Maryland / Department of Certificate of Ce		ygiene	2010	21010	
Physici	an/	Registrar			Reg. No. 2. Date of Death 3. Time of Death		
** dical Exami		Robert Eugene	Durham	Month August 21	Day Year , 2010	0118 hrs	
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death		
		Franklin Square Hospital Rosedale			Baltimore County		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir		h(MM/DD/YYYY) 9. Birl Foreig	n	
Direction .		215-70-6171 1\overline{X}M 2 F 49 Yr	S.	August	20,1961 Co	^{intry)} Maryland	
any		10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits	
≱ .	ŗ	Maryland Baltimore Dun	dalk			1 Yes 2 No	
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code		10	10g. Citizen of What Country?		
h the] 3a or		7821 St. Bridget Lane 21222			USA		
eath with the Maryland items 23a or 28a-f show ust he notified at once.	neral		as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,	
ter dez ", or i	Fune	1 Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: Whit		
ours af	To Be Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind of		16b. Kind of Business/li		
6 72 ho m "ng cal Ex		Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life, DO NOT use ret	ired)			
within giene.		10 years Ca 17. Father's Name (First, Middle, Last)	rpenter		Free Land	e	
215-0036 be filed within 7 tral Hygiene. 'ked other than ent, the Medica		Malcolm Childress	18.Mother's Name				
212 212 213 214 215 215 215 215 215 215 215 215 215 215		Malcolm Childress Barbara Bosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				Zip Code)	
MD d 2 shc lth and n 27 is			St. Bridget Lane	, Dundal	k,Md. 21222		
s lan of Heal		1 Burial 2 K Cremation 3 Removal from State crematory or o	sition (Name of cemetery, ther place)	ust 28,	20c. Location - City or		
Baltimore, permit. Pages 1 an Department of He (important: If ite		4 Donation 5 Other Specify: Bayview	Crematory 20	010	Baltimore,	MD.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenside 22.	Name and Address of Facility nnelly Funeral Ho 10 Sollers Point	ome Qf D	undalk,P.A.		
Physician		23a. Part I. Enter the disease, or complications that caused the death to not enter	10 Sollers Point the mode of dying, such as cardiac of	Road, D	undalk, MD. st, shock, or heart	21222 Approximate Interval	
/Medicat		failure. List only one clause on each line. Immediate Cause (Final disease a. Oxycodone And Alcohol Intoxication; Heroin Use Death					
Examiner		or condition resulting in death) Due to (or as a consequence of):		HCLOIH .	300		
	٦	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Ë	cause. Enter Underlying Cause (Disease or injury that initiated					
red	Examine	events resulting in death) Last Due to (or as a consequence of):					
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Ox 68760, suth certificate be excattending physician for use as the burial.	sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery		
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cords law require has been s 2 should	Completed			24a. Was a autops	y prior to co	opsy findings available ompletion of cause of	
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:					
of Vir	의	1 Yes 2 No Prospital 1 Inpatient 2 FR/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		g Home 5 F	Residence 6 Other:		
ion of tending Pheath.	ig	Natural 5 Pending Fd 8-21-10 Fd 12.	1 Ves 2 → No	unknown	,, 000		
VISION Atto	fica	Accident investigation			28f. Location (Street and Number or Rural Route Number, City or Town, State) 8213 Pulaski Hgwy.		
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide (Specify) nouse #112 Rosedale, Md.					
E 7 7 H		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
To the within To the comple	Medical	and manner stated 29b. Signature and title of certifier	29c. License number	Turio timo, dato d	29d. Date signed (Mon		
		Margaret D. March	O.C.M.E.		August 21, 2010		
		30. Name and address of person who completed cause of death (Item 23a)					
	1		enn Street, Baltimore, MD 2	21201		4	
St Regist		31. Date filed (Month, Day Year) 32. Regetting Signature					
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AMEND TITEM#20a76e22perFH C90719/2/2010 WS
State of Maryland Department Of 10 and Mental Hygiene
mend Items 4b,c per dr. 2907.09/30/2010 and Mental Hygiene
Certificate of Death

Reg. No. 2 1 Amend Items Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOMNE Month Year 1:15 AM ONALN 2010 106051 /Medical 4b. City, Town, or Location of Death Randallstown 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner IM ORTITUSSI 1+011 Baltimore Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1945 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 65 Director 218-50-2020 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at MD Director Baltimore 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 N. Paca Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2K No Specify: ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Francis Downes Martha Frances Maddox Item 27 is marke other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sherrie Downes - sister 6314 Elmview Dr; Arlington, Texas 76018 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 to Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) in state Cremation Svcs8-30-10 Ardent Hanover, Maryland Ronald S. Wade 22. Name and Address of Facility State Anatomy Board
Marzullo Funeral Chapel Properties Director 6009 Hartord Road Baltimore 22 23a. Part 1 Enter the dise se, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate duse (Final RESPIRATORY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG CANC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and P.O. Box 68760 the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify). □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? of Vital Records, 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1∐Yes 2∐wMo 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVITE J KIHWICHW 5401 0 RANDAUSTOUN MO 21137 KHUNKHUN 040 (art rn 31. Date filed (Month, Day, Year) 32/Registrar's Signature State AUG 30 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ellis Physician/ Month 7 and ett PM 8:58 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10808 Green Mountain Columbia, USA If Under 1 Year If Under 2 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Min. (Month, Day, Yea Director 217-56-8359 57 Maryland 953 April Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showning any injury or other traumatic event, the Medical Examples. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10808 Green Mountain Circle 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Specify: black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Roland Dunnock Henrietta V. Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kia Braddy - daughter 10808 Green Mountain Circle; Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🖾 Donation 5 🗌 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of un relative Licensee 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shock Interval Between Onset and Death Immediate Casse (Final Weta static Ph_sician/ 20 disease or condition 3 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence on if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death
Unknown 5 Other (specify) Yes 2 No page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifier 2010

Registrar
DHMH 17 Rev 7/2009

State

Charter

10710

32. Registrar's Signature

Columbia

Suite 6020

ess of person who completed cause of death (Item 23a) (Type, Print)

MI)

Knight

lement B.

2010

31. Date filed (Month, Day, Year)

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Heather Lynn For	1	1- For State Certificate of Death	Hygiene	ZUIU	21013
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death 1846 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of December 29493 Nancy Street Easton	ath	4c. County of Death Talbot	
Funeral Director	,	5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24h	Hrs. 8. Date of Birth	(7) Foreign	hplace (State or n untry)
nd show any 10%		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 5 NO 1-0 m 1-3 H			10d. Inside City Limits 1 Yes 2 No
ı the Maryla 3a or 28a-f otified at o	Dire		10g	Citizen of What Coun	itry?
fter death with "", or items 2.	Fune	1 3 Wildowed 4 Divorced III Yes, Give Year 1 1 Yes 2 A No. Specify		14. Race - Americ White, etc. Specify:	can Indian, Black,
36 in 72 hour han "natu lical Exan	ompleted by	15 Decades Studentian (Specify only highest grade completed) 160 Decades Liquid Occupation (Give kind	of work done 1 retired)	6b. Kind of Business/Ir	ndustry Eli KG
Ore, MD 21215-0036 cs 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic ovent, the Media	Bec	ERNEST FRANCIS FOCENCY MAJIC	Hy (First Middle) Wa	iden.Sumame)	Clouky
MD 21: and 2 should balth and Mer on 27 is mar	٩	1) comany's lame/ic lations/lip (Ty) Print) 19b Mailing ress (\$ N beg	pr - ral Route Number	ar, Gity pr T State OHO 1 Acation - Oftwork	Zip Godel 239
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Baltime permit. Pag Department Important injury or of		21. Fignature of Furieval Service (School 22. Name and Address of Facility 2100 to 000 to 000 DW AVE	BYA / ED . M.	Approximate Interval	
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x 68760, the certificate be exwittending physician ruse as the burial.	cian/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)		23d. Date of delivery Month Da	ay Year
O. Box lat the death of by the attenteracted for us	바	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
IS, P.(ted by		1 Yes	2 No 3 Proba	ably 4 Unknown
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as	Completed		autopsy performe 1 Yes 2	prior to co ed? death?	ompletion of cause of
/ital	o Be (25. Was case referred to medical examiner? Hospital: 1 Legation 2 EB/Outpetion 2 DOA Other Nur.		esidence 6 🗸 Other:	Scene
l of \ling Phy	H۲	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work?	28d. Describe how		
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	Certif	Suicide 6 X Could not be determined (Specify) House	easton,	te)29493 Nand MD	cy St
2 >	70		and due to the cause(sed at the time, date an	s) and manner as state d place, and due to the	d. cause(s)
To with To con	Me		2	29d. Date signed (Mon	
4 4		O.C.M.E.		August 26, 2010	
Of reva		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
Sta Registr	te			_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .[□]201<u>0</u> Physician/ Dorothy M. Freeze August 23, 1:15 P. Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium Social Security Number 7. Age (In yrs. 92 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Days Hours Min. April 4, 1918 219-07-0597 Mar VI and Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 Tes 2 X No Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 21234 USA 1730 Wentworth Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc or ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural" Completed 3 😡 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyghene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elmer Rittase Margaret Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Breshe/ Attorney 409 Washington Avenue Suite 600 Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemen 08-27-2010 Baltimore Maryland Signature of Funeral Service Lie 2. Name and Address of Facility Leonard Tresport Road Baltimore Maryland 21214 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician: disease or condition resulting in death) Medical Due to (or as a cons a uence of) **Examiner** Sequentially list conditions, 2010 Examine cause. Enter Underlying Cause (Disease or iinjury Directo for as a nunsequence of) that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial AUGUST 23, Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? DOROTHY FREEZE 24a. Was an autopsy performed' **Director:** After this certificate I 2 💢 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Date signed (Month, Day, Year) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D.TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

AUG 3 0 2010

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			For State Registrar	State of Ma		Certificate of i		vi c iilai i iy	Reg. No.	2010	27075
Н	Physicia	ın/	Decedent's Name (First, Midd			711		2. Date of De Month	Day	Year	3. Time of Death
-	Medic Examir		Jean 4a. Facility Name (if not institution	Jeanette n, give street and number)		Fike	or Location of Death	August		2010 County of Death	6:00 A ^M
-			Stella Maris Ho 5. Social Security Number	spice			lowson			Baltimo	re
	Funeral Director		5. Social Security Number 218–32–9389	6. Sex 7. Age (In yrs. last birtho 73 Y	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da September	th ''' ^{Year)} 10	oc Cour	
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	ryland -f sho ied at	ctor	10a. State 10b. Count Maryland Balt	imore	10c. City, Town	or Location Dundalk					10d. Inside City Limits
	ne Mar or 28a notifi	Dire	10e. Street and Number	THOLE		10f. Zip Code			10e Citize	en of What Cou	1 🗆 Yes 2 🔀 No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral Director	7142 Martell A	lvenue			21222			USA	ntry ?
	r item iner n		11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - Americ Black, White,	
Maryland 21215-0036	rs after ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🔀 Divorce	If Van Chus Z	0	1 ☐ Yes 2 🂢 No	Specify:		S	pecify: Whi	
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b 5	illed w Il Hygi I other	Be	17. Father's Name (First, Middle,	Last)		Hab WOLKEL	18. Mother's Nam	ne (First, Middle,			
ylar	id be f Menta arked atic ev	욘	Benjamin Shaeff	er			Ada Owi	ngs			
Man	shoul rand ranm:		19a. Informant's Name/Relations			Mailing Address (Street			-		Code)
e, r	and 2 Health tem 2:		Glenn A. Fike 20a. Method of Disposition	Son		42 Martell	· · · · ·			21222 ation - City or To	Chata
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other	Specify)	cemetery, Reisters	disposition (Name of crematory or other place town United M	eth. 20	st 30, 10	Reis	terstow	
Bal	permi Depar Impo any ir		21 Signature of Funeral Service	Licensee		22 Name and Address Connelly 1 7110 Solle	Funeral Hers Point	ome Of 1 Road, 1	Dunda Dunda	lk,P.A. lk.MD.	21222
	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	r complications that caused the only one cause on each line. a. ADVANCED Due to (or as a contract of the cont	DEMENT	TA	ng, such as cardiac	or respiratory ar	rest,	20	Approximate Interval Between Onset and Death
	ed sit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (or as a c	onsequence of)						
	ificate be executed ig physician and as the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of)	:					
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Box	Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3	су		23	d. Date of delive Month	ery Day Year
ls, P.O.	ulres that the des	ed by PI	Part II. Other significant conditi	ons contributing to death but	not resulting in t	he underlying cause gi	ven in Part I.				ne cause of death?
Records,	law requires has been sig je 2 should b	mplet						24a. Was autor	osv	24b. Were autoprior to codeath?	psy findings available mpletion of cause of
- R	i cian; The la certificate ha rector, page		25. Was case referred to medical					1 □ Yes	rmed? 2 X No	1 Yes	2 🗆 No
of Vital	Physician; this certific ral director,	To Be	examiner? 1 Yes 2 X No	Hospital:	2 ☐ EB/Outn	atient 3 DOA Oth	er:		longo 6 V	Other (Secolf)	HOSPICE
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ion	ittendii death. stor: Ai / the fu	Certificate:		igation not be		M 1 🗆	Yes 2 No				
Division	al or Attenos after deat I Director: d in by the		4 Homicide determ			, street, factory, office		28f. Location (S City or Tow		Number or Rural	Route Number,
_	To the Hospital or Atte within 24 hours after dea To the Funeral Directol completed filled in by th	Medical	(Check 2 Medical	g Physician: To the best of my Examiner: On the basis of exar g Nurse Practioner: To the be	mination and/or in	nvestigation, in my opinio	on, death occurred a	t the time, date a	nd place, ar	nd due to the cau	use(s) and manner stated.
	To th Comp		29b. Signature and title of certifie	'n_		29c. License				signed (Month, L	
			10	7		DY	13725		8	1261	0
	5 v		30. Name and address of person		-						
	Stat	e	TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	32 Belletrar's		LLEY RD. '	TIMONIUM.	MD 210	93		····
	Registra	ır	AUG 30	2010	1	L. e.					

AUGUST 26, 2010 6:00 a.m.

JEAN FIKE

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Pri					All Copies / // Mental Hygid	_	e.
	1	For State Registrar				tificate of D			3. No. 201	0.27076
Physician Medica		1. Decedent's Name (First, Middle, L William Joseph G						2. Date of Death Month August	Day 201	3. Time of Death 5:16 P M
Examine		4a. Facility Name (if not institution, gi Gilchrist Center		ce		4b. City, Town, or	Location of Death		4c. County of De	eath Limore
Funeral Director	- 1			e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. 1	Birthplace (State or Foreign Country)
show	. h	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	eation				10d. Inside City Limits
r 28a-f s	<u>≗</u> [Maryland Baltin	ore		Essex	10f. Zip Code		Lan	Civina a CM/h a L	1 ☐ Yes 2 🖾 No
s 23a o	- 1	714 Clover Avenue	9			212	221	10	g. Citizen of What USA	Country?
amin .	څ	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12, Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wi	merican Indian, hite, etc. Vhite
itnin 72 hour ene. than "natu the Medical	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		5+)	(Give k life. DC	ent's Usual Occupa ind of work done do NOT use retired) custodian		ing	6b. Kind of Busines Chur	
d be filed with Mental Hygis arked other atic event, t	8	17. Father's Name (First, Middle, Las Rudolph Grzech	t)					e (First, Middle, Ma Maryann]	iden Sumame)	
d 2 should alth and 1 27 is mare traums		19a. Informant's Name/Relationship Maryann Frances E		ster)				al Route Number, C imore, Ma		
Page 1 an nent of He int: If item iny or othe		20a. Method of Disposition 1		cer	metery crem	sition (Name of natory or other place ry Cemete	9)		oc. Location - City	or Town, State , Maryland
permit. Departr Importa any inju		21. Signature of Funeral Service Lie	ensee Jurkainka	7 /	22 Br 1 1	Name and Addres	s of Facility i Funeral	Home P.A	A. ex. Marvl	land 21221
hysician/		23a. Part 1. Enter the disease, or connock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	e.	Do not ente		g, such as cardiac			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a conseque	ece of):	3.1				
nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as	a conseque	nce of):					
Lrisia e	ᇹᅵ	resulting in death) Last	Due to (or as	a conseque	nce of):		_	_		
the attending physician and the for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy	у		23d. Date of Month	delivery Day Year
anec de de	≥	Part II. Other significant conditions	contributing to death t	out not resul	lting in the u	nderlying cause giv	en in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown
ate has bee	Completed							24a. Was an autopsy performe	prior t death	autopsy findings available to completion of cause of 17 Yes 2 No
certific irector,	å Re	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	: 2 D E	'D'Out-ation	26. Pla	ace of Death (Chec	k only one) ome 5 ☐ Residen	- Marker 6-	pecify) HOOCQ
ath. r. After this le funeral d	Certificate; To	27. Manner of Death Natural 5 Pending 2 Accident Investigat	28a. Date of inju (Month, Da	iry 2	28b. Time of injury	28c. Injury work	at	28d. Describe how		ecity) TOLOGO
s after de al Directo	Certif	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
in 24 hour the Funers	Medical	(Check 2 Medical Exa	hysician: To the best of miner; On the basis of e urse Practioner: To the	examination a	and/or invest	igation, in my opinio	n, death occurred a	t the time, date and	place, and due to the	ne cause(s) and manner stated.
within To the compl		29b. Signature and title of certifier	unda (1	NP		29c. License	number (5356	290	d. Date signed (Mo	onth, Day, Year)
5v		30 Name and address of person wh	o completed cause of c	leath (Item 2				ud Tom	SON M	150 C O
State Registra		31. Date filed (Month, Day, Year) AUG 3 0 2010		ar's Sanatu	fark			, ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **GLEN** URNIE ANNE ARUNDEL MEDICAL GTON If Under yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Count (Count) **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No evern 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after coppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally any or other traum." 1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Completed lack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ervisor Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARRIS poran 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HUOTE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown certificate has been si rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 H6 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAWMORE State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2237 M 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death timor Ba Baltimore 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Year) Months Days Min. 1 M 2 □ F 2010 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No ITIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 202 USA set Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fa NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) On Himore Somens MOZILIT -mother 1106 ath 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral S 5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approxi ate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

The law requires that the death certificate be executed P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Division of Vital Records, cate has been s page 2 should To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Hospital or Attending Physician: Medical Certification: To

Physician

/Medical

Examiner

Physician

Examiner

Director

Completed by Funeral

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantual to a public once.

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical Completed by Be

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature/and title of certifier,

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar 31. Date filed (Month, Day, Year) AUG 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hubiak Pauline 9:45 ugust 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Honkins Elderplus Assisted Living Baltimore al Security Number If Under 1 Year If Under 24 Hrs Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) 920 1 🗆 M 2 🔯 F Davs 207-03-9356 Hours Min Pennsylvania Director 89 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Baltimore Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States by Funeral 21219 2829 Lodge Farm Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give 3 ☒ Widowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Stetz Thomas Stavisky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
314 Locust Ave. Baltimore, Maryland 21221 Patricia Cooke (Daughter) Baltimórė, 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Vladimir Cemetery 8/30/2010 Lopez, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lipense 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition ung Medical resulting in death) Due to (was a consequence of **Examiner** anorexia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day led by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? anemia certificate has page 2 performed? Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🕱 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) (SSIST ed / W After this Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 16229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar astern

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20 2016 Joanne Yvonne Huber 1:05 Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Dec 2 Day, Year 35 1 □ M 2 🖾 I Hours West Virginia 212-32-8084 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 410 E. McPhail Road 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) police officer law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bayard Thomas Michael Anna Virginia Kline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2611 Johnson Mill Road; Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Kim Kaye - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation cemetery, crematory or other place) _3 Removal from State 4 Donation 5 Other (Specify) ture wonald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final--Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Year Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gartifying Nurse Practicener: 1. The best of my knowledge, death occurred at the time. Sate and place, and such cause (s) and manner as stated. 29b. Signature and title of certifier Nog

Registrar

DHMH 17 Rev 7/2009

6 65 West MacPhail Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khosla, M.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month J Howerton 2302 PM 2010 Medical 4a. Facility Name if not institution, give street and number **Examiner** 4b, City, Town, or Location of Death 4c. County of Death JOHNS HOPKING BAYNEW MEDICALCENTER BALTIMORE 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Aug 15, Yea New York Director 133-18-9906 84 1926 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 □ No 10e, Street and Number 10g. Citizen of What Country? USA 10f. Zip Code 21221 Funeral 1 Eastern Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No Black White etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unkပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Trailways Rd; Middle River, MD 21220 Bruce Howerton - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state ame and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 Inter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, peart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 ponths? should be detached for Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? perform certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2/1 No ဂ္ 1 Yes 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Medical Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: filled in by npleted

Natural 5 Pending 2 Accident Investiga	ation	injury M	28c. Injury at work? 1 \square Yes 2 \square No	28d. Describe	how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			ory, office		(Street and Number or Rural Route Number, own, State)
(Check	Physician: To the best of my know aminer: On the basis of examination the Praction of the best of m	n and/or investigation, i	in my opinion, death occurred	at the time, date	and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Month. Dav. Year)

29c. License number KES-000 29d. Date signed (Month, Day, Year) August 21,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parsons 4940 Eastern Avenue Baltimore, MD 31. Date filed (Month. Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $28^{\;\text{Day}}$ Aug. Physician/ 2010 5:22 A Illback Grace Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Edenwald Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2x F 92 Months Days Hours Min. Mar Month, Pay, Year 918 Connecticut 04**1-**18-6521 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 No Lanham Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 20706 U.S.A. 6935 Cipriano Woods Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Business Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Martha Sorensen Christian O. Hayden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6935 Cipriano Woods Ct. Lanham, Maryland 20706 19a. Informant's Name/Relationship (Type, Print) Lynn Illback/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Paramus, New Jersey 8/30/2010 Wash. Mem. Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 🗌 Yes 2 🗀 No 25. Was case referred to medical 26, Place of Death (Check only one) Be examiner? Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner 28c. Injury at 28d. Describe how injury occurred Certificate: atural Accident Suicide 5 Pending 2 🗀 No M 1 Yes Investigation after death Director. filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 24 hours a Funeral L Medical 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hc

To the Fune

completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number rs completed cause death (Dem 23a) (Type,

DHMH 17 Rev 7/2009

State

Registrar

AUG 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physic	an	Registrar 1. Decedent's Name (First, Middle,	Last)	d / Department of He ,08/30/2010dhb Certificate of D	2. Date of Month	Death Day	Year	2708 3. Time of Peatri
/Medi	cal	VANESSA	A. JONES	4b. City, Town, or L	AUGUS	7 23 7 4c. County	ZOIO of Dogth	1548 [™]
Examir	ner	4a. Facility Name (If not institution, S		BALTMON		4c. County	oi Dealii	
Funeral		Social Security Number 6	Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year Yrs. Months Days		Day, Year)	9. Birthpla Countr	ce (State or Foreig
Director		214-70-5641 Usual Residence of Decedent	50	713.	11-	25-1957		FID
72 hours after death with the Maryland 'natural", or Items 23a or 28a-f show Iteal Examiner must be notified at	_	10a. State 10b. County	10c. City,	, Town or Location			100	d. Inside City Limits
28a-f	Director	MD Bain	more Kai	10f. Zip Code		10g. Citizen of V	Vhat Country	
3a or		9503 Oak 7	Trace Why	2113	33	Tog. Olazen or v	USA	, .
permit. Tages I and 2 should be fine whith 72 thous are beauthwith the way had been made and the white way had been and the way had been and the way in the principle of Health and Mental Hygiene. Important: If the Z7 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nothined at once.	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		panic Origin? (Specify Yes or , Mexican, Puerto Rican, etc.)	No- 14. Rac	e - Americai k, White, etc	
l', or li	by Fi	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠No If Yes, Give Year or Dates:	1 □Yes 2 No	Specify:	Specify		CIC
atura Ical E		15. Decedent's (Specify only highest)	Education	16a. Decedent's Usual Occupa: (Give kind of work done du		16b. Kind of Bu	-	
iene. r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired)	Canada I'A	B. 1/2	0 i	2/2/
Hygie other 1 ent, th		17. Father's Name (First, Middle, La	ast)	Finger Print	8. Mother's Name (First, Midd	lle, Maiden Surnam	(0.1 ne)	olice Deg
Mental arked o	To Be	Wilmer	Tones		Constance	Tones		
z should n and Mer is marke raumatic	ľ	19a. Informant's Name/Relationship		19b. Mailing Address (Street as	nd Number or Rural Route Nui	nber, City or Town,	State, Zip C	Code)
Health Fem 27	4	DIONNE Arrington 20a. Method of Disposition	-Tittk/Sister	ace of Disposition (Name of emetery, crematory, or other, place	n Kuad, Yur K	20c. Location -	City or Tow	n, State
ages ent of nt: If It ry or o		1 D Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State	metery, crematory or other place	8-28-2010	Towso	•	
Department of Important: If any injury or once.		21. Signature of Funeral Service Lic		27. Name and Address	of Facility Aughn C.	rreene Fo	meral	Services
2	() H	Vauchn (. Preeze	8728 Liber	ty Road Ran		n1) 8	1133
		23a. Part 1. Enter the disease, or co shock, or hear failure. List or	omplications that caused the death. By one cause on each line.	. Do not enter the mode of dying	, such as cardiac or respirator	arrest,		Approximate nterval Between Onset and Death
hysician		Immediate Cause (Final disease or condition resulting in death)	a COMPLICATION OF	metastatic ba	ast cancer			
/Medical Examiner		105dilling in dodality	Due to (or as a consequent	ence of): IARY BRONCHUS I	WEENSNIK ME	DACTATIO THE	un©	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequent			1 4/1		
and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с		1 Prut	ELLEN EXMIN	ER	
physician and the burial-transit	edical E	rossing in county cust	Due to (or as a conseque	ence or):	James Brut	81		
	Med	IF FEMALE:			Va.			
e attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy			te of deliver onth	y Day Year
	nysic	1 □ Yes 2 ™ No 9 □ Unknown	9 Unknown	Sauri Signification (Specify)				
ate has been signed by the	by P	Part II. Other significant conditions	s contributing to death but not resul	ting in the underlying cause giver		d tobacco use cont		
s been signed I		V			1	∐Yes 2 No	3 Proba	bly 4 🗌 Unknov
has b	Completed				24a. W	topsy	Were autops prior to com death?	sy findings availab pletion of cause of
		25. Was case referred to medical	<u> </u>		1 □ Ye	s 2 No	1 ☐Yes 2	2 MNo
is certific director,	To Be	examiner?	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 ☐ DOA Other	26. Place of Death (Check on 4 □ Nursing Home 5 □ R		er (Specify)	
r death. ector: After this certificaby the funeral director, p	T:uc	27. Manner of Death 1 □ Netural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury Work?	at 28d. Descrit	e how injury occurs	red	
death. ctor: A / the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ho I	1320 M 1 1 UY	ABLATI	on metrust	ATIC.	TUMOR
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within 24 hours after de To the Funeral Directo completely filled in by the	edical C	(Check only 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinati	vledge, death occurred at the tim	e, date and place, and due to		anner as sta	ated.
ithin 2 o the 1 omplet	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License		29d. Date signe		
≥ ≥ 5) are	ms	D060		AUGUST		
	1 1		XIII			וכאטאקו	4)	
201		30. Name and address of person wh	no completed cause of death (Item	23a) (Type, Print)				
20V		30. Name and address of person when LYNNE A. SKARYA 31. Date filed (Month, Day, Year)		EST REIVEDERE	AVENUE, BAL	DMORE,	ND Z	1215

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G907 9/10/10 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ 10:00 AM Allen Jackson 2016 Gilbert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, Town, or Location of Death Examiner Health Core System ecil Manyland ないりさ 8. Date of Birth (Month, Day, Year) 8-9-1960 If Under 1 Year I Under 24 Hrs. 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours N.C. **Director** 216-78-6040 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore MD na 1 X Yes 2 ☐ No 10g. Citizen of What Country?
USA 10e. Street and Number 10f. Zip Code 21218 3702 Loch Raven Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et Completed by 1

✓ Never Married 2

✓ Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of MD Inspector 12th grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carrie Hubbard Willie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3702 Loch Raven Blvd Balto, MD 21218 19a. Informant's Name/Relationship (Type, Print) Katrina Jackson-Sister Baltimore, 20a. Method of Disposition 20b King, remortally park 9/03/2010 20Ramma11stown SMD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 9 - 7 - 2010Garrison Forest East F/H March 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21202 Balto, 1101 E.North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIME Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 2 🗌 No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MECUIUS The law requires 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? DUE TO MY CROMA 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural or Attending 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 20390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Health Care System, Perry Point, MD 21902 VA Mani State Registrar

1201 jo

Jackson

Physicians

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Name Knewn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	-		rtment of H <i>ificate of D</i>		nd Me			0010	07005
			Registrar 1. Decedent's Name (First, Middle, Last)					eaur	2	Date of Dea	Reg. No	2UIU	3. Time of Death
	Physicia Medio			Edith A	nna S	Juti	la			Month August	Da 2	3 2010	
<i></i> .	Examin	er	4a. Facility Name (if not institution, give st				4b. City, Town, or I		Death		40	County of Deal	
	Funeral		8229 Long Point F 5. Social Security Number 6. Sex		In yrs. last birtl	nday)	Dunda If Under 1 Year	I L K If Under 24	Hrs. 8	Date of Birt	h	9. Bir	ore Co. thplace (State or Foreign
	Director		213-26-1229	M 2 1xF 80		Yrs.	Months Days	Hours	Min. N	(Month, Day	Year)	23 Oh	untry) 10
	nd how at	۱	Usual Residence of Decedent 10a. State 10b. County	17	10c. City, Town	or Loca	ation		-				10d. Inside City Limits
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336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy oritory or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		If	as Decedent of His Yes, specify Cuban Yes 2 X No	, Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	hours hatur dical	olete	15. Decedent's Edu (Specify only highest grade	cation	16a.		ent's Usual Occupa nd of work done du		f working		16b. K	Kind of Business	
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	ecute and II-trans	Exan	Cause (Disease or iinjury that initiated events c resulting in death) Last		consequence o	of):							
0	cate be executed physician and the burial-transit	edicat											
8760	tificate ng phy as the		IF FEMALE:										
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)					23d. Date of de Month	livery Day Year
<u>о</u> .	hat the ed by detacl	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in	n the un	derlying cause give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
l S	quires t	ed b	Osteoarthi	ritis						1 □ `	Yes 2	ØNo 3□F	robably 4 🗆 Unknown
COL	law rec las ber 2 sho	Completed	Diabetes							24a. Was a		prior to	topsy findings available completion of cause of
æ	sician: The law I certificate has k lirector, page 2 s									perfo 1 🗌 Yes	rmed2 2 N	death?	s 2 N o
/ital	sician s certif lirector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2 🗆 ER/Qu	to ations	Other	ce of Death				0 D Other (0-1)	
ot	ig Phy ter this neral d		27. Manner of Death	28a. Date of injury (Month, Day, Y	28b. T		28c. Injury work?			. Describe h		6 Other (Spec ry occurred	erty)
on	tendin leath. .or; Afi the fur	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				M 1 □ Y	es 2 🗌 N	lo				
Divis	ital or Att urs after d raf Direct led in by		4 Homicide determined	28e. Place of Injury building, etc. (m, stree	et, factory, office		281	Location (S City or Tow			ral Route Number,
	the Hospi nin 24 hou the Funer npleted fil	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse		mination and/or	r investi	gation, in my opinion	, death occu	urred at the	time, date a	nd place	e, and due to the	cause(s) and manner stated.
	Vit Cor		29b. Signature and title of cartifier				29c. License				29d. Da	ate signed (Monta	
		'	30. Name and address of person who cor	npleted cause of deal	th (Item 23a) (1	Type. Pr	D 4 (0/0
			Michael Douglas	s Martin	MD.	7	602 Bel	airk	di	Beltin	nes re	MD	21236
	Stat Registra		31. Date filed (Month, Day, Year) AUG 3 0 2010	32. Registrar's	Signature	1						•	

DHMH 17 Rev 7/2009

1 2 20	Exa	sicia edica mine	n al
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	1	For State	State of Mary		epartment of H Certificate of D			ZUIU	27086
	1	Registrar Decedent's Name (First, Middle, La	st)		Jertificate of L	Jean	2. Date of Deat		3. Time of Death
Physician /Medical		Marie Elizabeth	Kociol				Month August	Day Year 2010	3:50 A M
Examiner	48	a. Facility Name (If not institution, given	,		4b. City, Town, or			4c. County of Dea	
	5.	Bel Pre Nursing Social Security Number 6.8		n yrs. last birth		Spring If Under 24 Hrs.	8 Date of Birth	Montgom	ery thplace (State or Foreign
Funeral Director			□M 2⊠F 48		Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 21,	1962 Mar	yland
and w	-	sual Residence of Decedent Da. State 10b. County	10	Dc. City, Town o	or Location				10d. Inside City Limits
the Marylan 28a-f show notified at		MD Montgo		-	r Spring				1 □Yes 2¥ No
uth with the Mar 23a or 28a-f st ust be nutrified		De. Street and Number 2601 Bel Pre Ro	ad		10f. Zip Code 20906		10	0g. Citizen of What Co USA	l puntry?
ins after dea	١.	Marital Status □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Eve Armed Forces? 1	r in U.S.	13. Was Decedent of His If Yes, specify Cubar 1 □Yes 2 ☒ No	spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: V	
ed within 72 hours ygiene. ier than "natural", t, tre "Mulcal Eve Completed by	-	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		ecedent's Usual Occupa Give kind of work done di ife. DO NOT use retired) nomemaker	ation uring most of workin	g	16b. Kind of Business.	
filed w I Hygie other t ent, th	13	7. Father's Name (First, Middle, Last	unk			18. Mother's Name	(First, Middle, M	OWN home	2
Mental Mental arked catic everage.		, , ,				Patricia			
2 shot and N is ma is ma		9a. Informant's Name/Relationship (failing Address (Street a				. ,
1 and Health Sm 27 ther tr	20	Joseph Thomas Oa. Method of Disposition			14335 Bel Pi			ring, Mary.	
permit. Pages 1 and 2 should be filed within 73 D_partment of Health and Mental Hygiene. Important: If item 27 is marked other than "many Injury or other traumatic event, the Maria or or." To Be Completing Description of the many Injury or other traumatic event, the Maria or or.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Special	y)in state	cemetery,	isposition (Name of crematory or other place	1			rown, State
permil D-par Impor any in	2	1. Signature of Funeral Service Licer ROTALU	Wade, Wire	Vor	22. Name and Address			omy Board Baltimore	, MD 21201
Physician /Medical Examiner	li d	3a. Part 1. Arter the diseas., or com shock, or leart failure. List only mmediate Caus. Final lisease or conditio esulting in death)	plications that caused the one caus in each line. a. Due to (or as a co	_ 501	MOUS	g, such as cardiac of	r respiratory arre	NomA	Approximate Interval Between Onset and Death
executed in and ial-transit	if co	any, leading to immediate ause. Enter Underlying dause (Disease or injury hat initiated events	Due to (or as a co	onsequence of)	:		<u></u>		
tificate be execting physician an as the burial-tree	re	ssulting in death) Last	Due to (or as a co	onsequence of)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir		FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	ivery Day Year
quires that an signed I uld be det	Pa	art II. Other significant conditions of	ontributing to death but no	ot resulting in th	ne underlying cause giver	n in Part I.		eacco use contribute to s 2 □ No 3 □ P	
I: The law requirected has been so page 2 should	-						24a. Was an autopsy perform	y prior to	ntopsy findings available completion of cause of
s certif	' 25	5. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2	atient 3 DOA Other	26. Place of Death			
th. th. After this funeral d	27	7. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Tim	ne of 28c. Injury	at 2		nce 6 Other (Spe w injury occurred	cify)
tal or Attending Phys rs after death. ral Director: After this led in by the funeral dir Certification: To		3 Suicide 6 Could not b determined	28e. Place of Injury - building, etc. (5		, street, factory, office	2	8f. Location (Str City or Town,	reet and Number or Ri , State)	ural Route Number,
he Hospit in 24 hour he Funera pletely fille edical (2	9a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of miner: On the basis of exand manner stated	amination and/	leath occurred at the tim or investigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and manner a ate and place, and due	s stated. to the cause(s)
To the common co	29	9b. Signature and tine of certifier	•	M.	29c. License	57312	3	9d. Date signed (Mont	h, Day, Year)
		Name and address of person who	VE 00	55 (her folle	tdrive	JEII	icoff city	121042
State Registrar	31	AUG 30 2010	32. Registrar's	Signature	allod)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maust Year Klara Krul 12:15 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country)

TIVE ATME 8. Date of Birth **Funeral** Min. 0672071922 **Director** 213-33-7864 88 UKRAINE Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6950 MARSUE DRIVE, APT. 1A 21215 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ρ 1 Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amay rigury or other traumatic event, the Means one. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PHARMACIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ NAIIM KRUL **ENTA** REYTBLAT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SERGEY LEYBELMAN/HUSBAND 6950 MARSUE DRIVE, APT. 1A, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) HAR SINAI CONG. 08/27/2010 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mars 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Colon Cancer Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 2 No 9 Unknown Linknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed. 1 ☐ Yes 2 ☐ No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 8/26/10 ns Rajapamin.o 20057465 2835 Smith Av, S-235, Baltimore, MD. 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse, M.D

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month 24, P_M Josephine Legge August 4:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery Sahdy Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🗓 F Days Hours Min Months 195-22-3359 81 **Director** Pennsylvania Apr.10 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14421 Traville Gardens Circle 20856 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items may injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Health/Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Donia Filipina Anastasia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Legge - Son 360 Winged Foot Drive, Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Calvary Cemetery Aug. 28, 2010 4 Donation 5 Other (Specify) Altoona, PA 21. Sid ature of Juneral Service Lig 22. Name and Address of Facility Stevens Mortuary 1421 Eighth Avenue, Altoona, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Vascu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy 2 No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 24 hours after death. Funeral Director: Al 1 Yes 2 🗌 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D.

DHMH 17 Rev 7/2009

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State Registrar

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Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chena

9901

32. Registar's Sign

00065505

Center Drive, Rockville

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 17<u>,2010</u> Physician/ 3:00P M Alfred LeSage August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4240 Baden Drive Calvert Huntingtown 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign, Country)DISTRICT Of COLUMBIA 8. Date of Birth **Funeral** 1 XM 2 □ F Days Months Hours Min. (Month, Day, Year)
April 1, Director 579-64-2491 62 Usual Residence of Decedent 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2X No Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4240 Baden Drive 20639 U. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alfred LeSage, Sr. Margie Powers Branson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Fritz/Daughter 4242Baden Drive, Huntingtown, Maryland 20639 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If it any injury or of once, ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-20-10 Hanover, Maryland Ardent Cremation 22. Name and Address of Facility Marzullo Funeral Chapel, P. A Signature of Funeral Service Licenses michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleration disease or condition resulting in death) Coronary Verevier disease 1Cans Medical Due to (or as a consequence of) **Examiner** pertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dystipidemic Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide 2 🖵 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25359 08/20/10 Ci 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20602

DHMH 17 Rev 7/2009

State Registrar 12072 DUD LING CENTER

WALPORF MO

CASTRENCE, NO

32. Registrar's Signature

ARNEL 31. Date filed (Month, Day, Year

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

		for State	State of Ma		artment of F ertificate of		Mental Hygie -	2010	27090
		Registrar 1. Decedent's Name (First, Middle, Las	21)			Dealii	Reg.	No.ZUIU	3. Time of Death
hysici: /Medic		David D. Liles					Month August 1	Day 5, 2010	6:50 AM M
xamin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. County of Dea	
neral		5. Social Security Number 6. S		(In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bir	rthplace (State or Foreign
ector		722-10-4403	⊠M 2□F	88 Yrs.	Months Days	Hours Min.	Feb 7, 19	Nor	th Carolina
fed at	tor	Usual Residence of Decedent 10a. State 10b. County MD St. Ma	ry's	10c. City, Town or L Callawa					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
r 28a	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
s 23a o	ral	20230 Buck Redm			20620			USA	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:		. Was Decedent of h If Yes, specify Cub 1 □Yes 2⊠No	an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whit Specify: Wh	te, etc.
than "natur ve Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occu e kind of work done DO NOT use retire .nister	during most of work	king	religion	s/Industry
event, I	Be	17. Father's Name (First, Middle, Last) David Hudson Li		1112			ne (First, Middle, Mai Mae Taylo	den Surname)	-
27 is marke traumatic	욘	19a. Informant's Name/Relationship (Carol Liles - W	Type. Print)	19b. Mai	ling Address (Street) 230 Buck	and Number or Ru	ıral Route Number, C	ity or Town, State,	Zip Code) y1and 20620
nt: If item 2 ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5. ☐ Other (Specif		20b. Place of Disp cemetery, cr	position (Name of ematory or other pla	ce)	Date 200	c. Location - City o	r Town, State
Importar any injur <u>once</u> .		21. Signature of Euneral Service Licer		ctor	22. Name and Addre	ess of Facility Sta Baltimore	ate Anatom Street; E	ny Board Baltimore	, MD 21201
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s been signed by the attending priysi should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□ Ectopic pregnan	су		23d. Date of d Month	elivery Day Year
an signed i	þ	Part II. Other significant conditions of	contributing to death bu	at not resulting in the	underlying cause gi	ven in Fart I.			to the cause of death? Probably 4 Volume
12 %	Completed						24a. Was an autopsy performe 1 □ Yes 2 □	d2 prior to	autopsy findings available completion of cause of
rector	Be	25. Was case referred to medical examiner?	Hospital:		Oti	oer:	ath (Check only one)		
to the Funeral Director: After this certilicate its completely filled in by the funeral director, page	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 2 ER/Outpati ry 28b. Time Injury	of 28c. Inju	4 🗆 Nursing i	dome 5 Residence 28d. Describe how		pecify)
Director d in by the	ertifica	3 Suicide 6 Could not b 4 Homicide determined	0	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
etely filler	Medical C		nysician: To the best of miner: On the basis of and manner sta	examination and/or					
lo the compl	Me	29b. Signature and title of certifier			29c. Licen	se number 2597	I	. Date signed (Moi	
		30. Name and address of person who		eath (Item 23a) (Type 2.0.Box 66		dtown MD	20650		
Sta Registr		Jeffrey Chase 31. Date filed (Month, Day, Year) AUG 30 2010		ar's Signature		a cown jim			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2010 0931 AM 4ug oward Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** 4c. County of Death umma Baltimore 6. Sex If Under 24 Hrs. If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Y Min. 1 ☑ M 2 ☐ F 3 MaryTand 219-30-4413 77 Director Usual Residence of Decedent 28a-f show 10a State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Brooklyn 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 263 Rupert Circle 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White and Mental Hygiene. is marked other than "natural", 3 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) roofer home improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosemary Gorman Howard Lerp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Marjorie Lerp - wife 263 Rupert Circle; Brooklyn, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 1n State cemetery, crematory or other place Signature of Funeral Sen RO 113 1 22. Name and Address of Facility State Anatomy Board ice Licenses 655 W. Baltimore Street; Baltimore, MD 21201 23a. Par 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot, heart failure. List only one cause on each line. Immediate Cause Final Onset and Death Physician/ tocome disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. as been signed 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital Other: မူ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 19685

Registrar
DHMH 17 Rev 7/2009

State

22 S. Coreene St., Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rembroke

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27092 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Lipowitz Month Year 10:35 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death RANDALLSTOWN BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 W Days Director 097-18-7629 84 10/02/1925 Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director be notified BALTIMORE 28a-f MD OWINGS MILLS 1 ☐ Yes 2√√√ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 3712 BIRCHMERE COURT 21117 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥ No Specify: 3√√ Widowed 4 □ Divorced Completed WHITE Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SECURITY ADMIN. 12 SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ item 27 is marke other traumatic FORMAN **ESTHER BORG** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st tment of Health a tant: If item 27 i JUDSON LIPOWITZ / SON BIRCHMERE COURT OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEM 08/27/2010 BALTIMORE MD 22. Name and Address of Facility Signature of Funeral Service Licens SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE Tart 1. Enter the disease, or because the state caused they eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final End-Stage Dementia Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter orderlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 6 Other (Specify) 1 ☐ Yes 2 ☐ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Tyes

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Division of Vital Records,

Certificate: Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

2 🗌 No 28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie 29c. License number ns Rujapahne M.D DOUS7465 3/26/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S · Rayapa KSe, M · D · 25 35 Sm) Th

AV-5-235 - Baltimore, MD.

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Doris Physician/ Month Mann 4:42PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randa11stown Baltimore Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** Oct. 31,1924 Months Hours Min. 216-20-6639 85 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a, State filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo MD Baltimore Pikesville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 18 Village Rd. 21208 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceus... Armed Forces? 1 ☐ Yes XX No Black, White, etc. þ 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: "natural" Specify: White Completed 3℃Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) the Circulation Clerk Public Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) t. Page 1 and 2 should be file tment of Health and Mental rant: If item 27 is marked o ပ Carrie Byerly George Garman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. Linda MacLeod / daughter 902 Fordwood Circle, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Faiths Crematory & Chapel ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/10 Manchester, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. . Signature of Funeral Service Licenses . Held Elledo 1605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ END- Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate makes. Enter I incorping Examine Due to (or as a consequence of) the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execumiting 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-tre Physician/Medical Division of Vital Records, P.O. Box 68760 þ

Completed Certificate: To Be

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

nskyapame M.D

N.S. Rajapakse, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cause (Disease or linjury that initiated events	C						
resulting in death) Last	Due to (or as a conseq	uence of):					
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopic			23d. Date of de Month	livery Day	Year
Part II. Other significant conditions c	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		o use contribute to		
				24a. Was an autopsy performed!	death?	topsy findings completion of s 2 \(\sum \text{No}\)	available cause of
25. Was case referred to medical			26. Place of Death (Che	ck only one)			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 .	OCA Other: 4 Nursing H	Home 5 Residence	6 Cother (Shee	Dent hi	popies
27. Manuer of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju			
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specific		ry, office	28f. Location (Street a		ral Route Nurr	nber,

Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057465

City or Town, State)

Av. 5-235- Baltimore, ND. 21209.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

2835 Smith

			1 - State Registrar	ite of Maryla		rtment of l		Mental Hy	giene Reg. No.	0 27094
	Physicia	nn/	Decedent's Name (First, Middle, Last)				· .	2. Date of De	eath	3. Time of Death
-	Medic	cal	Frances Marie Mi 4a. Facility Name (if not Institution, give street ar	ller				August	23, 2010	10:18 A ^M
	Examir	ner	Alfred House	id number)		Rockvi	or Location of Dea	th	4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr		th 9.	Birthplace (State or Foreign
	Director	ı	397-05-3801 ^{1 □ M 2}	X ^F 95	Yrs.	Months Days	Hours Mir	Oct. 3	0, 1914	Country) WI
	and show at	5	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
	Maryla 28a-f etified	rect	MD Montgomery	Re	ockvill	е				1 🌁 Yes 2 ☐ No
	h the la or 2 be no	ā	10e. Street and Number			10f. Zip Code			10g. Citizen of What	: Country?
	tth wit ms 23 must	Funeral Director	18114 Cashell Road	Decedent Ever in U	S 42 W	20853		Sanaife Managaria	USA	
9	er dea or ite miner		1 Never Married 2 Married 1	ned Forces? Yes 2X No	If	Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	to Rican, etc.)		merican Indian, /hite, etc.
903	urs aff :ural", al Exa	ted	3 € Widowed 4 □ Divorced Yea	es, Give r or Dates.	1	Yes 2 XNo	Specify:		Specify: W	hite
15-	72 hor n "nat fedica	Completed by	15. Decedent's Education (Specify only highest grade comp		(Give k	ent's Usual Occup ind of work done ONOT use retired,	during most of we	orking	16b. Kind of Busine	ess Industry
212	within giene. er tha			ege (1-4 or 5+) 2		retary	,		I.R.:	S.
pu	filed valued by all Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surname)	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	Henry Klosterhuber				1		osterlitz	
Mai	2 shorth and the and the strain traum		19a. Informant's Name/Relationship (Type, Print) Fred Miller – Son)			and Number or A		er, City or Town, State n MD 208	
ē,	f Heal f Heal item other	. 7	20a. Method of Disposition	20b.	Place of Dispos	sition (Name of	I	Date	20c. Location - City	
E O	Page nent o ant: If iry or		1 ☑ Buriet 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crem Lvary Co	atory or other pla emetery		6-2010	Milwauke	∍, WI
3altimore,	epartr porta ny inju		21. Signature of Funeral Service Licenses	11			-		others Fur	
	<u>σ</u> υ = # α	- >>	23a. Part 1. Enter the disease, or complications	Mun					e, New Ber	T-
	ate be executed Wedical Examiner and the burial-transit	dical Examiner	shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, ke fing to Immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	on each line. on estive ue to (or as a consec ardiac Ar ue to (or as a consec trial Fib	Heart quence of): rhythmi quence of): rallati	Failure				Approximate Interval Between Onset and Death
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	cate by physic the b	edic	dA	rterioscl	erosis					
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t		in the past 12 months?	es, outcome of pregn Live Birth 2 Fei Pregnant at time of Unknown	tal death 3 🗌	Ectopic pregnand Other (specify)	су		23d, Date of Month	delivery Day Year
P.0	that t ined b e deta	by P	Part II. Other significant conditions contributing	g to death but not re	sulting in the ur	derlying cause gi	iven in Part I.	23e. Did t	obacco use contribut	e to the cause of death?
ds,	quires en sig ould b	ted	Pneumonia					1 🗆	Yes 2 ☐ No 3 ☐	Probably 4 🕅 Unknown
Recor	The law recate has be page 2 sho	Comple	Dementia					24a. Was auto perfo 1 Yes	ormed? death	autopsy findings available to completion of cause of 1? Yes 2 □ No
ita	sician certifi irector) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		lanca e e e	Oth	lace of Death (Ch			
of V	g Physer this eral d	te: To	27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ Date of injury (Month, Day, Year)	28b. Time of	28c. Injur	y at		dence 6 Other (S)	oecify)
on	endin eath. or: Aft	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(WORUT, Day, Tear)	injury	M 1 🗆	Yes 2 No			
Divisi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	al Certificate:	4 Homicide determined	Place of Injury - At h building, etc. (Specit	(y)			City or Tov	·	
	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier 1 X Certifying Physician: To (Check 2 Medical Examiner: On the control of the con	he basis of examination	on and/or investi	gation, in my opini	on, death occurred	at the time, date a	and place, and due to t	he cause(s) and manner stated
	To the within To the Comple		only one) 3 ☐ Certifying Nurse Practic			29c. Licens		lace, and due to th	29d. Date signed (Mo	
			> Oliver Sha	mees	s m	D254	10		August 24	, 2010
	5		30. Name and address of person who completed		, , , , ,	,	1	0.1		
	Sto		Oliver Lawless, MD 31. Date filed (Month, Day, Year)	32. Registrar's Signa		ince Phi	.11p Dr.,	Olney,	MD 20832	
	Stat Registra	·C	Auc on 20to		An es					

DHMH 17 Rev 7/2009

Box 68760 Records, Division or Vital To the Hospital or Attending Physician:

Maryland 21215-0036

Baltimore.

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1095

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Marshalee Dr. Elknidge, MDZ

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 22,2010 August Marguerite Dolores McManus 6:55P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Stella Maris Hospice</u> Timonium g. Birthplace (State or Foreign Country)

Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Month, Day, June 27 Ye*ar*) - 1<u>919</u> 1 M 2 F Director 214-12-1009 91 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 21093 U.S.A. 2525 Pot Springs Road, Apt. S510 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 X No Yes, Give 6:58 а.ш. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Marzullo Concetta Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26Delafield Court, Baltimore, Maryland 21234 Kevin McManus/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) State AnatomyBoard 8-22-10 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009Harford Road, Baltimore, Maryland21214 mukau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or at a consequence of). attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 5 Other (specify) 1 Yes 2 J 9 Unknown signed by the signed for the signed Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** ၉ 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After i 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours after To the Funeral Direc Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d Date signed (Month, Day, Year) 29b. Signature a d title of certifier 2010 US 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ERNESTINE

WRIGHT, MD

AUGUST

MCMANUS

MARGUERITE

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27097 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAYHEW 2310 PM AUGUS, 25 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICA CENTR BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Ohio 1 🗆 M 2 🗓 F Days Hours Min. Months 233-15-7825 Director 32 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director X□ Yes 2 □ No Sussex Millsboro Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21964 County Avenue 19966 U.S.A death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black. White, etc. þ 1X Never Married 2 ☐ Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Manager 12 Food Lion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, unk 2 Pauline Mayhew Guiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Guiler 101Rockdale Road, Apt. A Follansbee, WV 26037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. 8-30-10 | Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, RAUMATIC disease or condition DRAIN INSURY Medical resulting in death) Due to (or as a consequence of) CERTAICATION NO PROVED BY MEDICAL COMMINER Examiner Eequalitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year ed by the a Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PSEUDOANEMISM CAROTO 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No or Attending Physician: The 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 🗌 No 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After work? 1 ☐ Yes 2 🔯 No Natural 5 Pending 2 Accident 18.2010 05:15 AM Investigation 6 Could not be the Vehicle accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5

THELE 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Carwis Camp Rd Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo NPI 1447419247 AUGUST 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 BACTIMORE, MD KEVIN JONES GREENE ST

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2010

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Nicholas George		122arena 1- For State Registrar	St	ate of Mary	and /	•	nent of F cate of L		ia ivienta		Reg. No.	20	0	27098
Physicia Medical Exami	an/	1. Decedent's Nam Nichol			Мода	arella	,			2. Date of De Month August 2		Year		Time of Death 1024 hrs
				George on, give street and n		arerra		City, Town, o	r Location of			. County of I		
		9108 Sandr						Randallsto				altimore		
Funeral Director		5. Social Security N	034	6. Sex	7. Age (In yrs. last b	rthday) Yrs.	Months Day		Min. 09/19		F	9. Birthpl Foreign Countr	ace (State or y) MD
any		Usual Residence o 10a. State	10b. County		10	Oc. City, Tow	n or Location		-				10	d. Inside City Limits
and F show	ь	MD	Balt	imore			Randa	allstov	vn				1	Yes 2 No
Maryl r 28a- ed at c	Director	10e. Street and Nu					[1	Of. Zip Code			10g. Citiz	zen of What	,	?
with the		9108 Sa	ndra C	ourt 12. Was De	cedent Fy	ver in U.S.	13 Was [spanic Origin	n? (Specify Yes or N	No. T	USA 14 Race - A		Indian, Black,
death w	Funeral	1 Never Marri	ed 2 M		orces?	No				Puerto Rican, etc.)	,	White, e		indian, black,
after c	by F	3 Widowed		orced If Yes, Give Ye or Dates:	ar			es 2X No				Specify:	Whi	
hours "natur	ted	15. Decedent's Ed		cify only highest gra				Usual Occupa of working life		nd of work done se retired)	16b. K	and of Busin	ness/Indu	stry
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15-0 illed wi Hygie d other	ပျ	17. Father's Name							18.Mother's	Name (First, Middle	, Maiden	Surname)		
2121 ald be f Mental marke	To Be	Alfred 19a. Informant's Na		Mazzarel	.1a,		9b. Mailing A	ddress (Stre		olores Su er or Rural Route N				Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	Alfred J	. Mazz	arella, J	r.Br					rt, Randa				
rre, I s I and of Healt of Healt of Healt	Ì	20a. Method of Dis	oosition	3 Removal fi		20b. Place	of Disposition	n (Name of ce place)	metery,	Date	20c. L	ocation - Ci	ty or Tow	vn, State
Fage ment of tant:		4 Donation 5	Other Sp	pecify:				rest V		8/30/10	0	wings	Mi1	ls, MD
Ball permit Depart Impor		21. Signature of Fu	neral Service	Licensee				ne and Addres	1					Road
Physician	+	23a. Part I. Enter th			aused the	e death. Do r		ne Fune				ck, or heart	Α	21136
/Medical Examiner		failure, List on Immediate Cause (Final disease	a. Hypertensi	ve Athe	erosclerot	ic Cardiov	ascular Dis	sease					Between Onset and Death
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	ē	Sequentially list con if any, leading to im- cause. Enter Under	mediate	Due to (or as a	consequ	ience of):								
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ox 68760, zath certificate be executed attending physician and or use as the burial - transit	Medical Examine			d										-
60, ate be ex hysician	ğ	UNPENDED		AMENDED 23c. If yes.	autaama	of everyone					224	Date of de	live=	
5876 ortificat fing ph		23b. Was decedent past 12 months		e 1 Live b	oirth		2 Fetal	death 3	Ectopic p	regnancy		. Date of de Month	Day	Year
Box 687 death certific.	Physician/I	1 Yes 2 N	lo 9 📗 Unk	nown 9 Unkn		ne of death	5 Other	(Specify)						
that the d		Part II. Other signif	icant conditi			ut not resultir	ng in the und	erlying cause (given in Part	I. 23e. Did	tobacco u	se contribut	te to the	cause of death?
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	ed by	Chronic alo	ohol abus	e										4 V Unknown
aw requir	Completed										s an opsy orm <u>ed</u> ?		r to comp	y findings available bletion of cause of
Reco The lav ficate has	힝	-								1 ✓ Yes	2 No		Yes	2 No
/ital	۵ļ	25. Was case referr examiner? 1 ✓ Yes		Hospital: 1	Inpatient	2 ER/C	Outpatient 3		Othor	heck only one) Nursing Home 5	Resider	nce 6 🗸	Other: So	ene
of \oldsymbol{O} ng Phy	일 ::	27. Manner of Death		28a. Date (Month	of Injury	28b.	Time of Injur	y 28c. Inju	ry at Work?	28d. Describe				
sion ttendi death. ctor: ,	atio	1 Natural 2 Accident	5 Pend Inves	ing tigation					Yes 2 N					104 - St S
Division tal or Attendi us after death. al Director: A	Certification:	3 Suicide		not be mined (Specify)	e of Injury	/ - At home, f	arm, street, f	actory, office b	ouilding, etc.	28f. Location or Town,		nd Number o	or Rural F	Route Number, City
N 8 4 3 5				ysician: To the bes										
To the within To the comple	Medical	one) 2 🗸		miner: On the basis and manner s	of examin tated.	ation and/or	investigation			rred at the time, date				
	Σ	29b. Signature and	utie of certifie	\cap	10			29c. Licens O.C.I				ate signed ust 24, 20		Day, Year)
) i	-	30. Name and ad re	ess of person	who completed caus	se of deat	th (Item 23a)		1 3.3.			, age			
+1				MD. Assista	ant Meg	dical Exam	11 M 11 M	11 Penn St	reet, Balti	imore, MD 2126	01			1
Sta Registi	ite	31. Date filed (Mont	2010	an 32 Pc	egistrar	Signatur	July 1							
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			ror		d / De	partment of H	Health and N	•		gible.	
			State Registrar 1. Decedent's Name (First, Middle, Last)		C	ertificate of	Death	2. Date of De	Reg. No. 2	0 0 Year	27090 3. Time of Death
	Physici: /Medic Examin	al	Larry Eugene McKi 4a. Facility Name (If not institution, give street and numbe	nney		4b. City, Town, o	r Location of Death	August	20	2010 unty of Death	8:12P M
.4	Funeral Director	e.	219-58-0367 ^{1™ 2□ F}	ge (In yrs.	last birthda Yrs.		ion Bridg If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	Coun	lace (State or Foreign try) cyland
	aryland show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or					1	0d. Inside City Limits 1 XYes 2 □ No
	ith the M or 28a-f	Director	Maryland Carroll 10e. Street and Number		-	10f. Zip Code	ion Bridg	e	10g. Citizen	of What Coun	try?
5-0036	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	3 West Broadway 11. Marital Status 1 □ Married 2 □ Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 □ If Yes, Give Year or Dates	? ≹ No	S. 1	3. Was Decedent of H If Yes, specify Cub 1 □Yes 2 🖾 No	21791 dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - Americ Black, White, e	an Indian,
D-C [:	C 3 13	Completed	15. Decedent's Education (Specify only highest grade completed)	- \	16a. De	cedent's Usual Occup ve kind of work done . DO NOT use retire	oation during most of work d)	sing	16b. Kind o	of Business/Ind	dustry
8	be filed within that Hygiene. ed other than "event, In Mar		Elementary/Secondary (0-12) College (1-4or 6	5+)		disab			, Maiden Suri	disak	oled
_		To Be	Theodore S. McKinney		1		Hele	n Pitti	nger		
Mar	nd 2 sho alth and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) Helen P. Garber/ mother			illing Address <i>(Street</i> est Broadv		ral Route Numb Union Bi			,
saitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify)	∍	Place of Dis cemetery, co	position (Name of rematory or other place eek Cemete	ce)	Date	20c. Locati	ion - City or To	wn, State
Dall	permit. Departr Importa any inje		21. Signature of Funeral Service Moensee	'us		22. Name and Addre	ess of Facility Hai	rtzlerFi nion Br	uneral	Home	
2	Physician /Medical		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	line.	h. Do not e		-	-	-		Approximate Interval Between Onset and Death
,	executed n and ial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Due to (or a Due to (or a d	s a conseq	uence of):	D					10415
O. Box	e d the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗌 Feta	death 3	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	Sy .		23d.	. Date of delive Month	ery Day Year
Records, P.	law requires that th as been signed by 2 should be detach	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.							ne cause of death?	
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ı vıtal	Physician: r this certific ral director, J	To Be	25. Was case referred to medical examiner? 1 \[Yes \] 2 No Hospital: 1 \[\] Inpar	tient 2 🗆	ER/Outpat	ient 3 □ DOA Oth	26. Place of Deat er: 4 \(\sum \) Nursing Ho	-		Other (Specif	
To the Hospital or Attending Physician: The Inthinia Library hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	or Attending P fler death. Jirector: After t in by the funera	Certification:	27. Manner of Death 1								il Route Number,
	ne Hospital 124 hours a te Funeral I	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.								
	To the comp	Me	29b. Signature and title of certifier M. L	51		29 0 Ligens	e number 0330) -	8	gneg (Month,	110
	5V		30. Name and address of person who completed cause of	6 N		e, Print) PN 5	r., UN	1on Bi	UDG	€_ , N	1222
eg	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2010 Sensus	trar's Signa	ture Same	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AUGUST Helen Cecilia McMahon 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) Date of Birth **Funeral** (Month, Day, Year) 1/29/1917 1 □ M 2 💢 F 060-03-9670 93 Director Usual Residence of Decedent waith and Mental Hygiene.

27 Is marked other than "natural" or item. 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 XNo Director Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 719 Maiden Choice Ln, 21228 HR-604 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**X** No Specify White Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary China 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H fitem 27 Is marked ott r other traumatic even Be John A. Foley Helen C. McAleer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary J. McMahon / Son 12206 RIlland Ct. Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If ite any injury or o 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2010 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign ture of Funeral Service Licene 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine time to fee as a consumer of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 that the death certificate be Physician/Medical Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 r Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2-1NO Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1- Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No thours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funeral D Hospital 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ala 14

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20:57 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town 4c nty of Death SLLMINE 8. Date of Birth (Month, Day, Y March 28 Social Security Numbe If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 90 Days 1 🗆 M 2 💢 F 219-26-9811 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3707 Glen Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 √ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Underwriter Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Stark Gertrude Lenhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Northwood Court Orinda, California 94563 Owen Murphy/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) metery, crematory or other place) Hilltop Service Corp. 8/30/10 Towson Maryland 22. Name and Address of Facility Leonard J. Ruck Inc 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, framy, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s performed? Yes 2 N 2 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injun 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed call (Type, Print) of death tem 23a 019 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Physic /Medi Exami

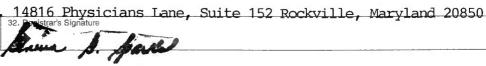
Funeral Director

1 = For State Registrar			-	Ce	rtificate of	Death			Reg. No.	י ח נ	0	0710	
1. Decedent's Name (Fin	rst, Middle, Las	t)						2. Date of Dea		U :	'ear	3 Time of Death	
Ruth	Doris	Miller	-					August				2:00 A M	
4a. Facility Name (If not	institution, give		4b. City, Town, o	r Location of D	eath		4c. C	ounty of	Death				
Sunrise As				1-46464-1	1 11 11 11 11	ville	Hre T	0. Data of Dire		10nt		ry lace (State or Foreig	
5. Social Security Number 539–18–968	- 11	ex □M.2. Dx F /.	Age (In yrs.	last birthday) Yrs.	Months Days		lin.	8. Date of Birl (Month, Da Mar 1.	y, Year)		Coun		
Usual Residence of Dec			02					race 1,	1520		714	Dilling COII	
10a. State 10b	o. County		10c. Cit	y, Town or Lo	ocation						11	Od. Inside City Limits	
	ontgome	ery		Rocl	kville							1x Yes 2 □ No	
10e. Street and Number					10f. Zip Code				10g. Citize				
118 Monroe	Street			0 10	2085		0 /0	-i6 - Va a - u Na		ited			
11. Marital Status 1 □ Never Married	2 St Marriad	12. Was Decede Armed Force 1 ☐ Yes 2	es?	.S. 13.	Was Decedent of I If Yes, specify Cub	an, Mexican, Pi	erto F	lican, etc.)	- 1		White, 6	an Indian, etc.	
3 Widowed 4		If Yes, Give Year or Date			1 □Yes 2 No	Specify:			5	Specify:	Whi	te	
15.	Decedent's Ed	ucation		16a. Dece	edent's Usual Occup	oation	andelen		16b. Kin	d of Busi	Business/Industry		
Elementary/Secondar	nly highest grad y (0-12)	College (1-4	or 5+)	life.	kind of work done DO NOT use retire	d) d)	WUIKIN	9					
12				Ho	omemaker	40.11	• •	(Final Add)		vn Ho			
17. Father's Name (First						18. Mother's				urname)			
John	Daniel			1.01 14 11			ına	Nord		T 01		0-4-1	
19a. Informant's Name/					ing Address (Street				-				
Marcia Gor	-	ignter	20b. F		6 Southla						-		
1 ☐ Burial 2 🔀 Cr	remation 3 🗆	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
4∐Donation 5∟			ate			i	. / 0 0	10040		. .			
21 Signature of Funera	Other (Specify	()	ate	al Jou	rney Crem	atory 8	_						
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State Registrar Shama R. Mittal, M.D.
31. Date filed (Month, Day, Year) AUG 3 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:30 a^M Jean McEvoy August Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care North Point Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 3,1927 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Hours Min. Country) Director 212-22-9397 83 Delaware Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Md. N/A Baltimore tx☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 6727 Graceland Ave. 21222 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. ò þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give 1 Yes 2X No Specify: Specify: White and Mental Hygiene. 3 Divorced Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Assistant Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva Angle William Wallace Hutchison permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. McEvoy Husband 6727 Graceland Ave. Baltimore, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27, 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2010 Signature of uneral Service Lic. 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. time 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Dundalk, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse in nce of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) physician and s the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached for 1 Yes 2 9 Unknown g Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas , page 2 autopsy performed Hospital or Attending Physician: The this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred After injury 1 Natural 5 Pending death. nours after death neral Director: A filled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical

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Registrar DHMH 17 Rev 7/2009

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29a. Certifier

(Check

only one

31. Date filed (Month

29b. Signature and litle of certifier

MALIKA WASERM

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

709

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

BASTERN

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BLVD

29d. Date signed (Month, Day, Year)

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Laura Newsome Aug. 26, 2010 P^{M} 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Overlea Nursing Home Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 19, 1927 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 220-12-9090 82 MD Director Usual Residence of Decedent 10a State 10c City Town or Location 10d Inside City Limits 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examinat must be realled at MD Baltimore Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1722 N. Broadway 21213 USA death y Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes ※☐ No permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Eventment 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 TYes 2X No Specify Specify: Black þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Union Hill Bessie Hill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruffin Hill (1st cousin) 3 Fens Ct. Essex, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Green Mount Crematory Of Other place) Aug. 31,201 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Sta Baltimore, Md. 4 ☐ Tonation 5 ☐ Other (Specify) ature of Funeral Service Licensee ^{22. Name and Address of Facility} Calvin B. Scruggs Funeral Home E Preston St. Balto, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Exami and Due to (or a a con Division of Vital Records, P.O. Box 68760, attending physiclan for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2No 3 Probably 4 Unknown page 2 should Completed peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes 1 □ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 12 Natural 2 Accident 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐ Yes investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 29c. License number

Registrar

State

31. Date filed (Month, Day,

AUG 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

Year

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06:30 AN Krystal Nicole Overby August 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
April 23, 1995 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F 219 43 8061 Director 15 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore MARYLAM) Rosedale 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7913 32nd Street 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married 2 X No Completed by Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John N. Stange Jr. Tina Overby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 32nd Street Baltimore, Maryland 21237 Tina Neisser (Mother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State permit. Page Department Bayview Crematory Inc. 9/2/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final methotatic Ewini Chcer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Diretor that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 「以 つ かに から しん しん しゃ しゅ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the un<mark>d</mark>erlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypertranicminasemia 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tel of Baltimore, 2401 W. Belvedere Are Beltimore, h 19101 State

DHMH 17 Rev 7/2009

Registrar

10-06275 Chinwe Masi Ogbonna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	.egible	9.	
State of Maryland / Department of Health and Mental Hygiene		2010	2710
Certificate of Death			_ , , ,

		1- For State Cer	rtificate of	Death		Re	eg. No.	
Physici edical Exami		1. Decedent's Name (First, Middle, Last) Chinwe Masi Ogbonna	ì			2. Date of Dear Month August 19	Day Year , 2010	3. Time of Death 2242 hrs
		4a. Facility Name (if not institution, give street and number) 14900 River Road	41	b. City, Town, or L Potomac	Location of Dea	-	4c. County of De Montgomer	у
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 M 2 F 47		If Under 1 Year Months Days	If Under 24H Hours Mi	_		Birthplace (State or reign UK Country)
nd show any cce.	ır	Usual Residence of Decedent 10a. State 10b. County PG 10c. City,	Town or Locatio		sville			10d. Inside City Limits 1 X Yes 2 No
the Maryla a or 28a-f	Director	10e. Street and Number 2721 Nicholson St. #104		10f. Zip Code	0782	11	0g. Citizen of What C USA	ountry?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Insperanten of Health and Mental Hygiene. Insportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican, Puer	Specify Yes or No- o Rican, etc.)	14. Race - An White, etc	
36 iin 72 hours af ihan "natural dical Examin	ompleted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16b. Kind of Busine Private	ss/Industry				
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Be Com	17. Father's Name (First, Middle, Last) Chinweze Madukwe		1		ne (First, Middle, M bel	Maiden Surname) Masi	
MD 212 2 should b th and Men 27 is marl umatic eve	ToE	19a. Informant's Name/Relationship (Type, Print) Jacqueline Onyeka/ Sister	19b. Mailing / Lat F	Address (Street, 20 Fox	and Number or ley Ln.	Rural Route Num , Purley		ete, Zip Code) England, UK
Baltimore, MD remit. Pages 1 and 2 sh Department of Health and Important: If item 27 is njury or other traumat		1 N Burial 2 Cremation 3 Removal from State	rematory or other	Cemeter	у 8-	Date 28-2010	20c. Location - City Germantov	,
Balti permit. Departn Import	/	1. Signature of Funeral Service Lignsee	105	83 Midd	leport 1	Ln. Whit	lor II FH e Plains,	
Physician Museli al Examiner		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	Cardio				est, snock, or neart	Approximate Interval Between Onset and Death
	r	or condition resulting in death) Due to (or as a consequence of b. Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of Due to (or as a consequenc						
, ii	Examiner	(Disease or injury that initiated events resulting in death) Last						2
O, e be executed ysician and burial - transit	Medical E	d. MENDED 23a,27	per me	g907 9-1	-10 vt	- "		
9 ta de al	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 are (Specify)	Ectopic pregr	nancy	23d. Date of deliv Month	ery Day Y ear
P.O. B es that the de igned by the e detached the	by	Part II. Other significant conditions contributing to death but not re	sulting in the un-	derlying cause gi	ven in Part I.			to the cause of death?
Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certificate death. After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the contract of the standing led in by the funeral director, page 2 should be detached for use as the contract of the con	Completed					24a. Was a autop perfor	sy prior t med? death	
ician: s certifi rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient		of Death (Checl		Residence 6 ✔ Ot	her Scene
n of V ding Phys h. After thi funeral di	on: To	1 Yes 2 No Impatient 2 27. Manner of Death 1 X Natural 5 Pending	28b. Time of Inju	ury 28c. Injury	y at Work?		now injury occurred	
Divisio Isl or Atten Is after deat al Director led in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific)	ome, farm, street,			28f. Location (S or Town, S		Rural Route Number, City
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	4 ☐ Homicide 29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my knowledg one) 2 ✓ Medical Examiner: On the basis of examination ar and manner stated.	je, death occurre	ed at the time, dat on, in my opinion,	te and place, an	d due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
To To Cor	Med	29b. Signature and title of certifier		29c. License O.C.M			29d. Date signed (I August 20, 20	
		30. Name and address of person who completed cause of death (Item Donna M. Vincenti, MD Assistant Medical Exam		Penn Street,	Baltimore, N	MD 21201		
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's lignatur	Bar					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. _ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Vinson Pyett 2016 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3altimore Baltimore University speciality HOSPI, tal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–17–1935 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**反** M 2□ F 127-26-7917 ΑÎ Director 74 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1 XYes 2 No na Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a U S A

14. Race - American Indian,
Black, White, etc. 1725 Chasley Avenue 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3☐Widowed 4☐Divorced Be Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Management Inspector 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Pyett Jimmie Lee Perdue ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Erma Ellis -Sister <u>1725 Chasley Avenue Balto, MD 21234</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-2-2010 Laurel, MD MD National Mem 22. Name and Address of Facility March East F/H 21. Signature of Fusial Service License any in 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ungemi hysician /Medical Tue to (or a consequence of): Examiner ncephalopath Sequentially list conditions. Due to (or a / a conse ue / e of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Prince Funeral Director: After this certificate has been signed by the attending physician and seizure Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, outrach Collar Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only and manner stated. within 24

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6015.

Charles St

29c. License number

29d. Date signed (Month, Day, Year)

 ρ_{oncler} , $m_{s}'lburm$ ox 68760 Baltimore, Maryland 21215-0036

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			1 _ State	State of Mary	•	epartme C <i>ertifica</i>			, ,	giene Reg. N2	010	27108
			Registrar 1. Decedent's Name (First, Middle, Last)		`			Cutif	2. Date of Dea	ath		3. Time of Death
	Physicia Medic	al	Milburn J. Ponder,					-		, ZOTO	3:34PM	
	Examin	er	4a. Facility Name (if not institution, give stree Doctor's Community		L		Lan	Location of Death			ince Ge	
	Funeral Director		220-30-3020		yrs. last birtho	Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day November	h , Year) 2, 19	9. Birti Cou Was	nplace (State or Foreign intry) nington, DC
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town							10d. Inside City Limits
	e Mary r 28a-f notifie	Director	Maryland Prince Geo	Green		Zip Code			10 - 0'1'-	en of What Co	1 X Yes 2 □ No	
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.			edent of Hi becify Cuba 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ican Indian, , etc. Lte		
15-0	72 hour n "natu ledical	Completed	15. Decedent's Educa (Specify only highest grade of		1 6	Decedent's Us Give kind of v ife. DO NOT u	vork done a	ation luring most of worl	king	16b. Kind	d of Business I	ndustry
212	within giene. er thar , the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	I		,	tation E	ngineer	Tr	ansport	ation
Maryland 21215-0036	d be filed Aental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last) Milburn J. Ponder	, Sr.				18. Mother's Nan		Maiden Su	irname)	
, Man	nd 2 should ealth and N m 27 is ma er trauma		19a. Informant's Name/Relationship (Type, David E. Ponder /					and Number or Rui				Code)
nore	age 1 ar ent of Ha nt: If iter y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of I cemetery Fort Li	crematory o	r other plac		Date /2010		twood,	Town, State Maryland
Baltimore,	permit. P Departm Importal any injul		21. Signature of Fuse al Service Licensee			22. Name	and Addres	s of Facility	no P A			more Avenue e, MD 20781
i			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complete the complete shock is the complete that the complete shock is the complete shock in the complete shock in the complete shock is the complete shock ind	tions that caused the	e death. Do no							Approximate Interval Between
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Box 68760	or the hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the aftending physic completed filled in by the funeral director, page 2 should be detached for use as the bit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin 9 Unknown	Fetal death	3 Ectopi 5 Other		у		23	3d. Date of del Month	ivery Day Year
P.O.	s mar m gned by se detac	by Ph	Part II. Other significant conditions contril	buting to death but r	ot resulting in	the underlyin	ig cause giv	en in Part I.				the cause of death?
rds,	require been sig	eted							24a. Was			obably 4 Hinknown opsy findings available
3eco	ne iaw ite has l	Completed							autor	osy ormed?	prior to death?	completion of cause of
tal	cian; i	Be	25. Was case referred to medical examiner?	pital:			26. Pla	ace of Death (Chec				
of Vi	y Physicar this ceral direction	e: T o	27. Manner of Death	1 Impatient 28a. Date of injury	28b. Tir	me of	28c. Injury	4 ∐ Nursing H ∕at	ome 5 Resid			fy)
ion	tending leath. tor: Aft the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Ye		ury M	work? 1 ☐ Yes 2 ☐ No					
Division of Vital Records,	Io the hospital or Atendands Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.		4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		n, street, fact	ory, office		28f. Location (S City or Tow		Number or Rui	al Route Number,
	Io the Hospital within 24 hours a To the Funeral I completed filled	Medical	Tribo and 3 Confilheres Numa Pr	On the basis of exam	nination and/or	investigation,	in my opinic	on, death occurred a	at the time, date a	and place, a	and due to the	ause(s) and manner stated.
	Vithin Congression	_	29b. Signature and title of certifier	_ ~	00	2	9c. License	number DJ H O		29d. Date	signed (Month	Day, Year)
	71/		30. Name and address of person who comp		h (Item 23a) (Ty	. /	0 1			7 1=	100	11-
	Stat	0	1. Date fil (Month, Day, Year)	η <i>8 8</i> '32. Reg a	GOOU Signature	Fuck	12000	Lanho	yn mi	· %0	106	
	Registra		31. Date file (Month, Day Year). AUG 3 0 20	70 3	4 .	La	10. 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PZZU **Physician** August 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital N/A 9. Birthplace (State or Foreign Country) 1929 New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Days 1 X M 2 | F June 03, 059-22-6598 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Baltimore Timonium Md. 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 316 E. Ridgely Rd. 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status and 2 should be filed within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Law Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Evelyn DiPietro Frederick Pezzulla 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or any 316 E. Ridgely Rd. Timonium, Md. 21093 Mrs. Rita Pezzulla/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-4-10 Timonium, Md. Dulaney Valley Mem. 21. Signature of Junera 22. Name and Address of Facility Ruck lowson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ischimic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Sarcome Metastaric requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death
9 Unknown Day 5 Other (specify) Yes 2 No P.O. signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 **N**o 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 XX 2 🗌 No Physician: completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Apatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 1 2 ER/Outpatient 3 DOA ပ္ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural (Month, Day After 5 Pending investigation the Hospital or Attending 1 Yes 2 No death. 2 Accident after death Director; A 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2

State Registrar

31. Date filed (Month, Day, Year) AUG 3 0 2010

KEUIN

29b. Signature and title of certifier

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORNES

ORIGINAL

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

26,0010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pflaumer 00:25AV Ellen Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City. Town, or Location of Death ux N/A Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F 0ct. 29 Mary and 82 Director 243-34-2457 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore Md. Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Rd. S-625 21093 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 2 X No 1 Never Married 2 X Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", White 3 Divorced 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teaching Assistant Balt. Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Griffith Clifford Sibley Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. R. Michael Gill/ Son 6519 Abbey View Way Baltimore, Md. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 Donation Hilltop Service Co. 8-30-10 Towson, Md. 21. Signature of Funeral 22. Name and Address of Followson Funeral Home, Inc. <u> 1050 York Rd. Towson, Md. 21204</u> art 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 A No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 70 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide work? 5 Pending 40 Investigation 10 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Pla e of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Practice or Table 2015 and manner stated Configure Practice or Table 2015 and manner stated Configure Practice or Table 2015 and manner as stated. (Check only on 29b. Signature and title of certifier 29c. License number ame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 3 0 2010 32. Régistrar State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Charles Edward Phillips Jr. August 10:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🔯 M 2 🗆 F Months Days Hours Min. Feb 9, 1952 **Director** Yrs Mary Land 58 219-60-5093 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 🗵 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 8824 Goldentree Lane 21221 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🖾 Divorced Completed and Mental Hygiene.
is marked other than "natural raumatic event, the Medical 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) accounting it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygin rtant: If item 27 is marked other ijury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard Paul Catlett Grace Maria Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Grace Catlett - mother 8824 Goldentree Lane; Essex, Maryland 21221 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signalur Funeral Service 655 W. Baltimore Street; Baltimore, MD 21201 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, otheart failure. List only one cause on each line Interval Between Immediate Cause (Final Adenoc Onse and De th Physician/ Ct disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNo Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) s after deau. ral Director: After hv the fir 5 Pending injury work' 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🖪 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

State Registrar Registrar's Signatu

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 10e per fib. 9906 8-30-10 yr and Mental Hygiene State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month <u>14:</u>30^R Ernest Panagiotidis 25,2010 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Nursing Home Dundalk Baltimore 8. Date of Birth (Month, Day, Year) 4-19-1933 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F 77 216-52-2132 Director Greece Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "kade." Examir or must be retified at MD 1 XYes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4711 Eastern Aveneu Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) unknown <u>Unknown</u> Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ဂ 19a. Informant's Name/Relationship (Type. Print) Priest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father Michael Pastrikos permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once. 520 S. POnca Street, Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State Greek Orthodox 8-27-10 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANLER **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate 1 ☐Yes 2 MNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. leral Director: A filled in by the fu 2 Accident 1 TYes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

72 hours after

Maryland 21215-0036

Baltimore,

law requires that the death certificate be executed

68760

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of Vital Records,

Division

Hospital or Attending Physician:

death.

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)



Place Dundalk MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17 State Por Maryland / Bepartment of Health and Mental Hygiene

Certificate of Death

			1 _ State	to State of Ma	aryland/1	Départment o Certificate o		and Mental	Hygier	ne		
			Registrar 1. Decedent's Name (First, Middle, La	est)		Certificate 0	Deam	2. Date o	Reg. f Death	No.20+0	3 Time of Death	3
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planet.	Examir		4a. Facility Name (if not institution, give	e street and number)	. ,	4b. City, Town	n, or Location o			4c. County of Dea	th	
		H	5. Social Security Number 6. S	1.011	On to	hdav) If Under 1 Ye	timor ar If Under		15:11	1		_
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	and show 1 at	ō	10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limit	s
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	with the s 23a or s	Funeral Director	10e. Street and Number 1610 Mussula Ro	ad		10f. Zip Coo 2128			_	Citizen of What Co	ountry?	
, , 9800	urs after death ural", or item I Examiner m	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify C	uban, Mexican,	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: White	e, etc.	
15-(i 72 hou an "nat Medica	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Oc (Give kind of work do life. DO NOT use retir	ne during most	of working	16b	Kind of Business	Industry	
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Maryland 21215-0036	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Emil Straterho					r's Name <i>(First, Mid</i> ry Elizab			€	
, Mar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		19a. Informant's Name/Relationship (7 Daniel Goldberg		19b	. Mailing Address (Stre 3911 De Lo						
Baltimore,		13 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other Speci	Removal from State	cemeter	Disposition (Name of y, crematory or other p	olace)	Date	20c.	Location - City or	Town, State	
Balti	permit. Departn Imports any inju		21. Signature of Emeral Service Licent ROTILATO		/			State Ana ore Street			MD 21201	
			3a. Part 1. Enter the disease, or com shoot or heart failure. List only of	p leations that caused	the death. Do n						Approximate	
-	hysician/ Medical	2. 1	Immediate Suse (Final disease or condition resulting in death)	a D Su	1-4	unth,	~;a				Interval Between Onset and Death	į
	Examiner		ſ	Due to (or as a	consequence o	n):						
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence o	nf):		- -				_
	icate be executed I physician and s the burial-transi	edical Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence o	f):						
760	cate be	edic		d								_
Box 68	death certifi ne attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Partal death	3 ☐ Ectopic pregn. 5 ☐ Other (specify)				23d. Date of del Month	livery Day Year	
О	nat the	/ Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting ir	n the underlying cause	given in Part I.	23e. D	id tobacco	use contribute to	the cause of death?	
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Division of Vital Records,	To the law requires that the white A working the law requires that the within 2 hours after deading. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed by	Hyperter	510				24a. W a p	las an utopsy erformed? es 2	prior to o	topsy findings available completion of cause of $2 \square$ No	
īg .	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		"		(Check only one)				_
<u></u>	Phys this (ral dir	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	1 Inpatie		patient 3 L DOA		sing Home 5 R			ify)	
ono	tending death. tor: After the fune	Certificate:	Tatural 5 ☐ Pending Control of the control of the	(Month, Day,	Year) in	jury w	ork? Yes 2 1		e now inju	ury occurred		
DIMIS	ortal or Arians after or al Director Iled in by		4 ☐ Homicide determined	building, etc.	(Specify)	m, street, factory, offic		City or	Town, Stat			
:	he Hosp in 24 ho he Fune ipleted fi	Medical	(Check 2 Medical Exami	sician: To the best of miner: On the basis of example Frantian or To the b	amination and/or	investigation, in my op	inion, death occ	curred at the time, da	te and plac	e, and due to the o	cause(s) and manner stat	ed.
,	Vith Con		29b. Signature and title of certifier	> phy	5,5	- 1	nse number		1	ate signed (Month		~
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			30. Name and address of person who d			ype, Print)						
	Stat Registra	e ır	31. Date filed (Month, Day, Year) AUG 3 0 2010	2. Registrar	s Si Ature	are of					250	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EN POLCAK 23 9:15 P M AUGUST 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 30) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Maryland 78 217-26-2716 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the resident Examination not institute. Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Hollins Ferry Road #201 21227 USA permit, Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the feet fraction in the most once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare nursing assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emerson Joseph Shiloh Henrietta Katherine Nussington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Greenwood Road; Linthicum, Maryland 21090 Kim Taylor - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 Othe (Specify) 21. Sign ture Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1 Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Immediate Ca Final disease or condition resulting in death) SEVERE COPD YEA125 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed ULMONARY EMBOLISM burial nding physician use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar SOUTH HANDY ER STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW FANE LLI

RES-00

BAUTIMORE, MD

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b-f Per INF G906 8/30/10 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 August 2:03 Α Mason Frederick Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Funeral 1 ፟ M 2 □ F Days Nov 10. 1926 Months Hours Min. Mary Land Director Yrs 216-20-9192 Usual Residence of Decedent 28a-f show 10a. State 10b. County Balto. 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shorexaminer must be notified at Director Perry Hall Harford 1 ☐ Yes 2 No MD Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1717 Pine 21014 Funeral Forest Court 4503 Dunton Terrance Apt K

Marital Status

□ Never Married 2 ★ Married

12. Was Decedent Ever in U.S.

Armed Forces?

1 ★ Yes 2 □ No 194 21128

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1945 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes Give 1947 Specify: 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu may injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) school librarian education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lena E. Kleylein Mason Knox Rose Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 Dunton Terrace Apt K; Perry Hall, MD 19a. Informant's Name/Relationship (Type, Print) Shirley Rose - wife 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board e of Funeral Service Lice ROMA L.d. Virector 655 W. Baltimore Street; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death ed by the a detached i Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural work' 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1) 25205 August 22, 2010 not 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Choules St. Bolto GBMC 6701 31. Date filed (Month, Day 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			Please Type or F amend #12 Per State of	rint in Black li	ndelible Ink. En	sure All Copie	s Are Legible.	
		-	For State Of State Of Registrar		rtificate of Death		Reg. No. 2010	27116
	Physicia	n/	Decedent's Name (First, Middle, Last)			2. Date of De Month	Dav Year	3. Time of Death
-	Medic	al	MELVIN ROBINSON 4a. Facility Name (if not institution, give street and number)	er)	4b. City, Town, or Locatio	Month	26 20/0 4c. County of Deat	07:05 AM
	Examin	er	U. OF MARYLAND MEDICAL SYS		BALTIMON		4c. oddiny di Boat	
	Funeral Director	1	5. Social Security Number 6. Sex 1 M 2 F 7. Usual Residence of Decedent	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Und Months Days Hours	er 24 Hrs. 8. Date of Bi	9. Birl (ay, Yaar) (1941	thplace (State or Foreign untry)
	aryland a-f show fied at	ector	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ 100
	ith the Mi 23a or 28 st be noti	Funeral Director	10e. Street and Number	a Ra	10f, Zip Code 2108	5	10g. Citizen of What Co	untry?
936	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 13 Yes 17 Yes, Give 17 Yes, Give 18 Year or Date	es?	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Ongin? (Specify Yes or No ean, Puerto Rican, etc.)	14. Race - Ame Black White Specify:	
21215-0036	2 hours "natur edical I	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during m	ost of working	16b. Kind of Business	Industry
121	within 72 /giene. ner than '	Com	Elementary(Segonday (0-12) College (1-4	or 5+)	on NOT use retired)		Federal	Government
nd2	filed w al Hyg d othe	Be	17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middle	f-	
Maryland	d Mental d Mental marked matic ev	Ţ	Meluso A · Kobios 19a. Informant's Name/Relationship (Type, Print)	01	ing Address (Street and Num	elen Bre	or City or Town State 7in	Code
	d 2 shoul alth and 1 27 is m er traum		Janet M. Robin So	30	3 Spry 1	- ,	oppa, MD	21085
Baltimore,			20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from St	20b. Place of Disponentery, cre-	osition (Name of matory or other place)	9/2/2010	20c, Location - City or	Town, State
Iţim	t, Pag tmen tant: ijury		4 Donation 5 Other (Specify) 21. Signature of Funeral Se Vice Licensee	(farrison	2 Hores Hen	etdy	Dwings/	AI II MI
Ba	permit Depar Impor any ir		1700 MO155	3	4905 Vo	-KPd.B	elto MD =	21212
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	line.	ter the mode of dying such		rrest,	Approximate Interval Between Onset and Death
120000	Examiner	į.	Sequentially list conditions, b.					
	ed	Examine	if any, leading to immediate Due to (or cause. Enter Underlying Cause (Disease or iinjury	as a consequence of):				
	executed ian and irial-transit	Еха	that initiated events C.	as a consequence of):				
		dica	d					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Euneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	1 Yes 2 No	th 2 ☐ Fetal death 3 [nt at time of death 5 [Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
P.O.	at the ed by the detached		9 Unknown Part II. Other significant conditions contributing to dea		underlying cause given in Pa	art I. 23e. Did	tobacco use contribute to	the cause of death?
JS, F	uires th	ed by				1 □	Yes 2 No 3 □ P	robably 4 🗌 Unknown
Division of Vital Records,	The law req ate has bee page 2 shoo	Completed				24a. Was auto perf 1 ☐ Yes	opsy prior to death?	topsy findings available completion of cause of s 2 No
ital	ician:	Be	25. Was case referred to medical examiner?		Other	eath (Check only one)		
l of V	ling Phys	ate: To	27, Manner of Death 1 Natural 5 Pending 28a. Date of (Month,	patient 2 ER/Outpatie injury 28b. Time o Day, Year) 28b. Time o injury	of 28c. Injury at work?	28d. Describe	idence 6 Other (Spec how injury occurred	.ify)
vision	or Atteno ifter death Pirector: / in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	Injury - At home, farm, str , etc. (Specify)		28f. Location	(Street and Number or Ru wn, State)	ral Route Number,
Δ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical (29a. Certifier 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis	of examination and/or inves	stigation, in my opinion, death	occurred at the time, date	and place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	Ž	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my knowledge,	29c. License numbe		29d. Date signed (Monti	
			Bydr fu		RES. O	000	Aug 26 6	2010
_/	12 v		30. Name and address of person who completed cause	27 C	CARRAGE	St Baltim	ort mD	21201
	Sta Registra		31. Date filed (Month, Day, Year) AUG 30 2010	istrar's Signature	who			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Paul J. Reed, Jr. 20Î Aug. 27 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oakcrest. Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 € M 2 □ F 214-05-3243 91 1919 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location od other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8800 Walther Blvd. #202 21234 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1√Yes 2 No If Yes, Give Year or Dates: 1942-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney and Mental Hygi 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Paul J. Reed, Sr. Marie Birmingham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a James Reed / Son 5 Norwick Circle, Timonium, Maryland other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If its any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 8/30/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASCVO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🗆 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours and the Euneral Director: Afternoral Director: Afternoral Director: Afternoral Director of the fu 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

wa (their

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

32. Registrar's Signa

10-06033 Daniel Rodriquez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aniei Rounque	, <u>, , , , , , , , , , , , , , , , , , </u>	1- For State Registrar	aryland / Departific Certific	cate of Death	na Mental Hyg	Iene Reg. No	2010	2711	
Physici Vledical Exam		1. Decedent's Name (First, Middle, Last)				Date of Death Month Day August 11, 20	Year	3. Time of Death 1816 hrs	
		Daniel Rodriquez 4a. Facility Name (if not institution, give street a	and number)	4b. City, Town,	or Location of Death		4c. County of Death	10101113	
		Washington Adventist Hospital		Takoma P			Montgomery		
Funeral Director		5. Social Security Numbelink 6. Sex	7. Age (In yrs. last bi	irthday) If Under 1 Ye Months Da	ave Houre Min	B. Date of Birth (MM pril 22,	Foreign	hplace (State or unk n intry)	
, in		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits	
nd show :	-	MD Montgomery	Takor	ma Park				1 Yes 2 No	
Aaryland 28a-f show any 1.at once.	Director	10e. Street and Number UNK		10f. Zip Code	unk	10g. C	itizen of What Coun	_{try?} unk	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient of Mental Figure I file manual. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.									
eath wi items	Funeral	1 Never Married 2 Married Am	as Decedent Ever in U.S. med Forces? unk		lispanic Origin? (Speci an, Mexican, Puerto Ric		14. Race - Americ White, etc.	an Indian, Black,	
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d with	Com	17. Father's Name (First, Middle, Last) UNK			18.Mother's Name (Fi	rst, Middle, Maide	n Surname) unk	· · · · · · · ·	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be								
D 21 should and Me	70	19a. Informant's Name/Relationship (Type, Prin Washington Adventist		9b. Mailing Address (Stre 7600 Carro1					
and 2 sho lealth and tem 27 is		20a. Method of Disposition	-	of Disposition (Name of c			Location - City or T		
Baltimore, permit. Pages I are Department of Hes Important: If itel injury or other tr.		1 Burial 2 Cremation 3 Remo	oval from State crema	atory or other place)					
altin mit. P partme portar ury or		4 Donation 5 Other Specify n s 21. Stonature of Funeral Service Licensee	, Director	22. Name and Addre	ss of Facility State	Anatomy	Board		
	_,/	Jenn IIIX			altimore St			MD 21201	
Physician /Medical		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.		not enter the mode of dying	g, such as cardiac or res	spiratory arrest, sh	ock, or heart	Approximate Interval Between Onset and	
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	nine	cause. Enter Underlying Cause	r as a consequence of);						
ed sit	Examiner	orono rodding in dodiny Edot	or as a consequence of):				- 1		
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED d AMENI	DED						
'60, ate be exe obysician re burial -	Med	IF FEMALE: 23c. If	yes, outcome of pregnancy	,		23	3d. Date of delivery		
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Is, P.C quires that en signed							✓ No 3 Proba		
COFC law re- has be 2 shoo	Completed					24a. Was an autopsy performed?		psy findings available mpletion of cause of	
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of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should be	Be	examiner? 1 Yes 2 No	Inpatient 2 🗸 ER/O		e of Death (Check only Other Nursing Ho	one) ome 5 Reside	ence 6 Other:		
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sion ttendi death. ctor: ,	atio	1 Natural 5 Pending 2 Accident Investigation		1	Yes 2 No				
Division tal or Attendi ts after death.	Certification:	Suicide Could not be	. Place of Injury - At home, fa ecify)	arm, street, factory, office	building, etc. 28f.	Location (Street a or Town, State)	and Number or Rura	Route Number, City	
spi fil		4 Homicide 29a. Certifier 1 Certifying Physician: To the		ath occurred at the time.	date and place, and due	to the cause(s) ar	nd manner as stated		
To the Ho within 24 b To the Fur completely	Medical	one) 2 Medical Examiner: On the b							
F > F 3	ž	29b. Signature and title of certifier		29c. Licen			Date signed (Monti	h, Day, Year)	
		Celorlewy		O.C.	.M.E. 	Aug	gust 12, 2010		
		 Name and address of person who completed Laron Locke MD. Assistant Me 		1 Penn Street, Balti	more, MD 21201				
		31. Date filed (Month, Day, Year)	<u> </u>	pare					
Regist	rar	AUG 3 0 2010	que p. y	Part					

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State of Maryland / Department of Health and Mental Hygiene 20 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year AM Fred Richard Medical 4a. Facility Name (if not institution, give street and Examiner City, Town, or Location of Death 4c. County of Death Hosp . Age (In yrs. last birthday) 75 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-30-3838 If Under 24 Hrs 1 🛣 M 2 🗆 F (Month, Da) Months Hours Min. Day, Maryland Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 Windsor Garden Lane Apt C433 21207 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces unit If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give Specify: black 3 Widowed XX Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a, Informant's Name/Relationship (Type, Print) Sinai Hospital 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 W. Belvedere Avenue; Baltimore, MD 21215 2121 Windsor Garden Lane Apt.C435 Balto. MD 2120 Roberson/friend Ruby 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ▼ Other (Specify) in state 21. Signature of the I Service Licen and I Service Licen 22. Name and Address of Facility State Anatomy Board W. Baltimore Street; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysician/ lays disease or condition resulting in death) Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cononcury autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Tes Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 000 016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (allimon MINOCINO filed (Month, Day, Year) . Registrar's Sign State AUG 3 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#5,20a-c,22perFH,G907.97 //2010 WS

State of Maryland / Department of Health and Mental Hygiene) 1 1 1 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 6220 PM 2010 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) WASHINGTON INFIRMAR LHAGERSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Numbers 62 Yrs. 1948 North Carolina April 9, 218-46-7463 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21746 USA 18601 Roxbury Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Specify: black 1 ☐ Yes 2 ☒ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Howard James Ray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 324 E. 22nd Street; Baltimore, Maryland 21218 Jeff Ray - brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State '4 □ Donation 5 3 Ener (Specify) In State 9/4/2010 Fayetteville, N.C. Northside Cem. T22 Name and Address of Facility States Anatomyp Board 21. Signature of Funeral Service Licensee

Physician /Medical Examiner

attending physician

detached the ል

Physician

/Medical

Examiner

10a. State

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Funeral

Director

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Items 23a

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Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Immediate Dause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consection of the to	quence of): quence of):	CARCINON	n/A	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
that initiated events resulting in death) Last	Due to (or as a consec	uence of):			
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	cc. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of c 9 Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Dther significent conditions cont	ributing to death but not re-	sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed	
25. Was case referred to medical	ath (Check on one				
examiner?	ospital: 1 npatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	jury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
27. Manner of Death Natural S Pending investigation					

ROAD, HAGERSTOWN, MD 21746

State Registrar

31. Date filed (Month, Day, Year) AUG 3 0 2010

COUN OTTEYMO 18601 ROXBURY 32 Registrar's Signa

ath (Item 23a) (Type, Print)

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM/operFH, G900, 8/30/2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUĞÜST HARRY ROSOFSKY 2010 10:05A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON **BALTIMORE** 5. Social Security Numbe 6. Sex 1 M 2 X If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min. 213-14-3292 Country) Director 90 Yrs. 01/02/1920 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A **BALTIMORE** XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 524 N. CHARLES STREET, USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2XX No 14. Race - American Indian, Black, White, etc ģ 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACROBAT **ENTERTAINMENT** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JA COB NETTIE ROSOFSKY GOFSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA GALINN/NIECE 18 MALIBU COURT, TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEM. PARK 5 Other (Specify) 08/27/2010 | RANDALLSTOWN, MD 21 Signature 22. Name and Address of Facility SOL LEVINSON & BROS. INC D 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, of complications that coshock, or heart failure. List only one cause on each complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician/ unonia 0 disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury that initiated events Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and n signed by the attending physician and Id be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) page 2 should be detached for in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WSDUC 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident
Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) HALUS Tomson W 31. Date filed (Month, Day, Year 32. Registrar's S State Registrar

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			9	31. Date filed (Month, Day, Year) AUG 3 0 2010	32. Re		ture						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 23 Summers August 4:50 P^{M} Edgerton Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours March 28, Director 89 West Virginia 236-18-0123 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the twat years. Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28a-f shon other traumatic event, the Medical Examiner must be notified at 23a or 28a-f show 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18131 Slade School Road 20835 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No. 1941

If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Specify: Year or Dates. White 1943 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter C. Summers Lola M. Bobbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Summers (Son) permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 18629 Tanterra Way, Brookeville, MD 20833 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 🗌 Cremation 3 🗌 Removal from State Groves Cemetery 8-29-2010 4 Other (Specify Summersville, WV 21. Sign ture of neral Service Lic 22. Name and Address of Facility Good Shepherd Mortuary 335 5th Ave., S. Charleston, WV 25303 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) a. Ascites Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Ornorhying Cause (Disease or iinjury Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of Cardiac Arrhythmia 24a. Was an cate has page 2 s autopsy performed? death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2X No |은 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, naninedo D70998 August 24, 2010

State Registrar 18101 Prince Philip Dr., Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Sumalatha Dhanireddy

filed (Month, Day, Year) AUG 3 0 2010 10-06365 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27124 State of Maryland / Department of Health and Mental Hygiene Nicole Judith Sumner 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1105 hrs **Medical Examiner** August 23, 2010 Nicole Judith Sumner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 12450 Valleyside Way Germantown Montgomery 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 6. Sex **Funeral** Months Days Hours Director 1 M Country) $2_{\mathbf{X}}$ F 25,1957 52 041-50-2633 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location any 1 Yes 2 No 28a-f show Montgomery Germantown with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 12450 Valleyside Way USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. d other than "natural", or items the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Pages 1 and 2 should be filed within 72 hours after death rout of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item 1 X Never Married 2 Married Yes 2 X No White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quince Orchard 12 5+ Teacher-Math & Computers High School 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Sumner, MD <u>Della Coassin</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Martin Sumner, MD/Father 652 Rosemont Lane, West Haven, CT 06516 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lawrence Mausoleum 8-28-2010 Donation 5 X Other Specify: Entembrent St. West Haven, CT 22 Name and Address of Facility Iovanne Funeral Home, Inc. permit. ature of Funeral Service License Bal 11 Wooster Place, New Haven, CT Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED attending physician for use as the burial -AMENDED 23a, PII, 27, 10/4/10 TT Division of Vital Records, P.O. Box 68760 23d, Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Sleep apnea Completed has been 2 should 24a. Was an 24b. Were autopsy findings available Multiple sclerosis prior to completion of cause of autopsy death? performed this certificate ✔ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 X Natural 1 Yes 2 No Pending within 24 hours after death Jirector: in by the Accident Investigation

State Registrar

To the Funeral

Medical

one)

3 Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

AUG 302010

Assistant Medical Examiner

32. Registrar's Signature

and manner stated

Could not be

determined

30. Name and address of person who completed cause of weath (Item 23a)

28e. Place of Injury - At home, farm, street, factory, office building, etc

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

August 24, 2010

29d. Date signed (Month, Day, Year)

or Town, State)

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Alphonso Shanklin 2010 27125 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0545 hrs Medical Examiner August 24, 2010 Frederick Alphonson Shanklin 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Baltimore** N/A717 Druid Park Lake Drive Apt.510 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days D.C. Country) Director 01/15/1963 47 214-88-4439 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. Baltimore N/A MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. Apt510 21217 717 Druid Park Lake Dr. permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes 1 Yes 2 No specify: Specify: Black 4 Divorced If Yes, Give Year <u>á</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Sinai Hospital 12th Grade House keeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Woodlawn Ave., Baltimore, MD 21215 Carolyn Shanklin(mother) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition tant: If it 1 Burial 2 Cremation 3 Removal from State 09/01/10 Baltimore, MD 4 Donation 5 Other Specify: King Mem. Park ²² Joseph H. Brown Jr. 21. Signature of Funeral Service Licensee FUneral Home 2140 N FUlton Ave., Baltimore, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medica Death a Acute Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED ed by the attending physician detached for use as the burial per ME G910 12/6/10 TT Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Р</u> О this certificate has been signed if director, page 2 should be deta 1 Yes 2 No 3 Probably 4 Unknown þ Hypertension; Diabetes Mellitus Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other, Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 V Yes After the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Yes 2 No 5 Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number ature and title of certifier 29b August 25, 2010 O.C.M.E. e and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. AUG 3 0 2010 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year August 26, 00:55Constance W. Stokes Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson 8. Date of Birth (Month, Day, Year 3/22/10// 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2X F Min. Hours Director 212-42-3423 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tyes 27 No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21207 6237 Robin Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ō 1 Never Married 2 Married by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give i Hygiene. other than "natural", SpecifAfrican-American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore City Schools Teacher and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louise Jackson David Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 6237 Robin Hill Road Gwynn Cak, MD 21207 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Yolanda E. Stokes / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 8/28/2010 Baltimore, Maryland Metro Crematory 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road Randallstown, Maryland 21133 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Pulmonany S Due to (or as a consequence of) Surcoidosis disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and I-transit Exami requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes 2 No 3 Probably 4 Unknown Completed 1 Yes 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 2 100 Hospital: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural

Natural

Accident

Suicide

Homicide injury 5 Pending after death. Director: Aft 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 🗜 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F 29b. Signature and title of certifier 29c. License number 100 00070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Bult more, MD Patel 6701 N Charles

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Division of Vital

		•	For State Registrar	orato or marylan		tificate of De		, ,	Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Las					2. Date of Dea	th	Year	3. Time of Death
	Medic	al	Helen 6 4a. Facility Name (if not institution, give	Stavropoulo)S	Al- City Town and	and a st Darth	FUeu	Day 26.1		\$\frac{\xi_{1}}{\cdot_{1}} \frac{\xi_{1}}{\xi_{1}} \frac{\xi_{1}}{\xi_{1}} \frac{\xi_{2}}{\xi_{1}} \frac{\xi_{2}}{\xi_{2}} \fr
	Examin	er	Saint Joseph		As a val bos	4b. City, Town, or L	Ocation of Death		4c. County	of Death	
	Funeral Director		220-50-0484	DM 287E	st birthday) 31 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. I		g. Birth Mar	place (State or Foreign y and
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	ation					10d. Inside City Limits
	Maryla 28a-f	Director	Md. Balt	imore		Luthe	erville				1 ☐ Yes 2XXNo
	n with the	Funeral D	10e. Street and Number 3 Nightingale W	lay		10f. Zip Code	21093		10g. Citizen of V	Vhat Cou	•
2-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11, Marital Status 1 (☑) Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐X No If Yes, Give Year or Dates.	lf.	as Decedent of Hisp Yes, specify Cuban, Yes 2 X No		cify Yes or No- Rican, etc.)		k, White,	can Indian, etc. hite
0-6121	n 72 hour e. ian "natu Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)		(Give ki	ent's Usual Occupati nd of work done dur NOT use retired)	on ring most of worki	ng	16b. Kind of Bu	_	
Z	d withi	Torist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)				Flor	a1				
yland	18. Mother's Name (First, Middle, Last) George P. Stavropoulos Sophia						^{Maiden Surname} Karange				
ary	hould and Me is mar	1	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street and					Code)
∑ 	and 2 s lealth a em 27 i her tra		Aphrodite Panos/Si	1		Lyden Roa	d Luthe	erville,	Maryla	nd 2	1093
baltimore,	Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🗷 Other (Specify	Removal from State C6	metery, crema k Orth	ition (Name of atory or other place) IODOX Cem.	8/30			re,	Maryland
Da	permit Depar Impor any in	lo d	21. Signature of Funeral Service Licens	of Ruch		Name and Address 150 York R			n Funer ryland		
Ą	nysician/ Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		the mode of dying,	such as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseque							D.4 L
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury that initiated events	b. Due to (or as a conseque		VILLIRE.					3 D = Y
2	tificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
5	E a E		IF FEMALE:								-
י סמי	or Attending Physician: The law requires that the death cert bridged death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use.		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor		ery Day Year
5, 7,	v requires that the book to be been signed by should be detact	þ	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the und	derlying cause given	in Part I.	23e. Did tob			ne cause of death?
ייייייייייייייייייייייייייייייייייייייי	The law requate has been page 2 shou	Completed						24a. Was ar autops perforr	SV P	rior to co eath?	osy findings available mpletion of cause of
5 .	nysician: The		25. Was case referred to medical examiner?			26. Place	e of Death (Check		2 No 1	☐ Yes	2 A No
	Physic this coral dire	유	1 ☐ Yes 2 📈 No 27. Manner of Death	lospital: 1 N Inpatient 2 D E 28a. Date of injury	R/Outpatient		4 Nursing Hor)
	ktending death. ctor: After y the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury		s 2 No	8d. Describe ho	w injury occurre	d 	
_ " -								City or Town			
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to constant only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and only one) 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and only one) 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and one to constant of the best of my knowledge, death occurred at the time, date and place, and date and place and date and place.					the time, date and	d place, and due	to the cau	use(s) and manner stated.			
	viti Con		29b. Signature and title of certifier Ludo J	adle m	7	29c. License nu	umber - 1971	2	9d. Date signed		Day, Year)
			30. Name and address of person who co	55	23a) (Type, Pri		NAME OF TAXABLE	T. Share	AUG 3.	0000000	
	Stat	C	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	TO BIVE	TEMSON.	1/4	AND E		
	Registra		AUG 3 0 2010 🗸	Green a. A.	Ex Kal						

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State Registrar

AUG 3 0 2010 Secret 1. Signature AUG 3 0 2010

who completed cause of de

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or P					-		•	
	•	For State Registrar	State of N	Maryland / [-	tment of F ficate of L		Mental Hy	/gien Reg. N	2010	27129
Physicia	n/	Decedent's Name (First, Middle NonMan	,					2. Date of De Month	D	ay Year	3. Time of Death
Medic Examin		NORMAN 4a. Facility Name (if not institution,	ELLSWORT give street and number,		-	b. City, Town, or	Location of Deatl	l August		7, 201 (c. County of Dea	
	·-	Frederick Mem				Freder				Frederi	lck
Funeral Director		5. Social Security Number 220–28–8978	6. Sex 7. A 1 X M 2 ☐ F	Age (In yrs. last birti 80		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Feb. 1	rth av. Yea <i>r)</i> 4	1930 ^{9. Bi}	rthplace (State or Foreign puntry) aryland
and show t at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locati	ion					10d. Inside City Limits
Maryl 28a-f otifie	irect		rederick				dsboro				1 🗌 Yes 2 🔀 No
vith the 23a or st be n	ral D	10e. Street and Number	atom Dd			10f. Zip Code	2179	ıΩ	10g. C	Citizen of What C	ountry?
items	Funeral Director	11438 Creager:	12. Was Deceden Armed Forces		13. Was	Decedent of Hi	spanic Origin? (Spanic Origin, Mexican, Puert	pecify Yes or No	-	14. Race - Am	erican Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Yes 2 If Yes, Give Year or Dates.			Yes 2 K No		o i noan, etc.,		Black, White Specify:	white
2 hours "natur dical I	Completed		t's Education st grade completed)	16a.		t's Usual Occup	ation Juring most of wor	kina	16b.	Kind of Business	
ithin 7; ene. r than the Me	Com	Elementary/Seconday (0-12)	College (1-4 o	r 5+)		IOT use retired) farme		i.i.i.g		dairy	•
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uld be I Ment narked natic e	ᄋ	Norman E. Stit			 			ey Blac			
12 shoulth and 27 is r		19a. Informant's Name/Relationsh Mildred I. Stit		l l	-		and Number or Ru			or Town, State, Zi	
of Head of Head if item		20a. Method of Disposition 1 X Burial 2 Cremation		20b. Place of	Disposition		1	Date	_	Location - City o	
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permi Depar Impol any ir		21. Signature of Frineral Service L	O. Xar	Elen		ame and Addres 4 S. Mai	ss of Facility Ha			eral Hom , MD 217	
Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each li	ed the death. Do none.	ot enter th	ne mode of dyin		or respiratory a	rrest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or a	s a consequence o	n):			-)		
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial director.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ☐ Fetal death at time of death		ctopic pregnanc ther (specify)	у			23d. Date of de Month	elivery Day Year
ires that the signed by detaction		Part II. Other significant conditio	ns contributing to death	but not resulting in	the unde	erlying cause giv	en in Part I.	23e. Did t		~	o the cause of death?
require been si should	letec							24a, Was			utopsy findings available
The law ate has page 2	Completed by								psy ormed? 2 2 N	prior to death?	completion of cause of
Physician: 1 this certifica al director, p	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec		7	10	7(11)
Physi rrthis c eral dir	e: To	1 ☐ Yes 2 No 27. Manner of Death	1 1 Inpa		ime of	3 DOA Othe	4 ☐ Nursing H	ome 5 Resi		6 Other (Spec	cify)
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To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practioner: To the	examination and/or	investigat	tion, in my opinio	n, death occurred a	at the time, date a	and plac	e, and due to the	cause(s) and manner stated.
To th To th comp		29b. Signature and title of certifier				29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
		1 /2 /	Lee 1	van_		MOD	35106		5	127/	2010

State Registrar Myung Hee Nam 400 w 7th St 31. Date filed (Month), Day, Year) AUG 30 2010 Server 9. Augustus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick, mo 21701

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Cordelia Shifflett 2. Date of Death 3. Time of Death Month Physician/ 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE VIEL 8. Date of Birth (Month, Day Year) Aug. 10,1910 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Months Hours Min, 1 □ M 2 🙀 F Virginia Director 220-24-7364 100 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Edgemere MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 2524 Brannan Avenue hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ XNo Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes Give Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home College (1-4 or 5+) Elementary/Seconday (0-12) Working/Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clementine Knight Sebert Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Bartley Ct. Nottingham, Maryland 21236 Mr. Norman Shiflett(Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State 8/30/2010 Baltimore, Maryland Oak Lawn Cemetery any injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun al Service License 22 Danda Ruck of Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 NO Yes ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medica 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 29c. License number apleted cause of death (Item 23a) (Type, Print) 4940 HD CCURSO 32. Registrar's Signature AUG 3 0 State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State of Mi	-	epartment of i Certificate of i			eg. No. O	
	Dhysisia	- /	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h ZUI	3 Time of Death
	Physicia Medic			Dorothy	Helen	Shafer		August		12:05 A ^M
	Examin	er	4a. Facility Name (if not Institution, give				r Location of Death		4c. County of Dea	
	Francis		1311 Willow Road 5. Social Security Number 6. Se		e (In yrs. last birthd		da1k If Under 24 Hrs.	8. Date of Birth	Balti	more rthplace (State or Foreign
	Funeral Director			¹ M 2 1		Months Days	Hours Min.	(Month, Day, Feb. 21	Year) Co	ountry) 1 ryland
	ryland -f show ied at	Director	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	r 28a notif	Dire	MD Baltin 10e. Street and Number	nore		10f. Zip Code	Dunda1		l0g. Citizen of What C	1 🗆 Yes 2🏗 No
	h with th ns 23a c nust be	Funeral	1311 Willow Road	1			21222		United Sta	
900	us after deat ural", or iten I Examiner r		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐XWidowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ②☑ If Yes, Give Year or Dates.	iver in U.S. No	13. Was Decedent of Head of Four If Yes, specify Cub1 ☐ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No No No No No No					during most of work		16b. Kind of Business Department Store			
Sales Clerk Store 7 Years Sales Clerk Store										
Maryland	ld be file Mental H arked o atic eve	To E	James Griffin					aungarde		
, Mar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Sylvia E. Shafer			Mailing Address (Street			City or Town, State, Zi ryland 21	p Code) 222
Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		cemetery,	isposition (Name of crematory or other plass of Faith	ce) Cem. 8/2	8/2010	20c.Location - City of Baltimore,	Maryland
21. Signature of Funeral Service Licensee 22. Name and Duda—Ru 7922 Wi							rss of Facility Funeral Ave. Du	Home of ndalk, M	Dundalk, I aryland 2	nc. 1222
			2 Part 1. Enter the dis 32, or comp shock, or heart failu List only or	olications that caused the cause on each line	the death. Do not			or respiratory arre	st,	Approximate Interval Between
radii (a	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	10rex(, , , , , , , , , , , , , , , , , , ,	Onset and Death 2 months
Same of the Same	Examiner				consequence of): ment					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	consequence of):					
	cuted nd transit	xam	Cause (Disease or iinjury that initiated events	C						
0	cate be executed physician and the burial-transit	ledical Examiner	resulting in death) Last	Due to (or as a	a consequence of):					
3760	ificate ng phy as the	Nedi		u						
Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗆 Fetal death	3	су		23d. Date of de Month	elivery Day Year
s, P.O.	v requires that the sbeen signed by should be detac		Part II. Other significant conditions co	-	ut not resulting in t	he underlying cause g	ven in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
cord	s law requi has been ge 2 shoult	Completed by						24a. Was ar	24b. Were au	utopsy findings available completion of cause of
l Re	ician: The la certificate ha ector, page.		25. Was case referred to medical					perform 1 Yes 2		s 2 🗆 No
/ita	ysician: is certific director,	To Be	evaminer?	Hospital:	ent 2 🗆 ER/Outp	Oth	lace of Death (Chec		nce 6 Other (Spec	
l of ∖	Jing J. After fune		27. Manner of Death 12 Natural 5 □ Pending	28a. Date of injui (Month, Day	v 28b. Tim	ne of 28c. Injur	y at k?	28d. Describe ho		опу)
DIVISION OF VITAI RECORDS. Safety of the form of the first of the form of the first of the form of the first of the form of t						M 1 L, street, factory, office	Yes 2 No	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
Ω	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Check 👺 🗆 Medical Exami	(Check 💆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and						
	To the within 2 To the comple	M	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the	best of my knowled	ge, death occurred at the 29c. Licens	e time, date and plac	e, and due to the	cause(s) and manner as 9d. Date signed (Mont	stated.
			help Le	lle Do		Hoo	55992		08 26	10
			30. Name and address of person who co Debuch L. Gello			pe, Print)	BAITIN	~0C, (~	021222	
	Stat Registra		AUG 3 0 2010	32. Registra	r's Signature			•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** AIHAOL 8 8 2010 STONE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CPRING MONTGOMER HOSPITA BR 220, NR If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Birthplace (State or Foreig Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under **Funeral** Year) Hours Days 1 M 2 F 20 **Director** NONE 16,2010 Usual Residence of Decedent illed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examble man be confined at 1 Yes 2 □ No Director UER SPRING C MONTGOMER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 912 JUBAI WAY 2170 SP Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2 ☑No Specify ģ Specify. 3 Widowed 4 Divorced NNK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFIA 7 is marked other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental CAMERON STONE ဂ္ LUCY MULLINEAUX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OIPOS MD 27 GLEN S.S. RE item 27 HOLY CROSS HOSPITAL 1500 POREST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ♣ Other (Specify) in State 21. Signau re Funeral E ryice Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Calle (Final disease or condition resulting in death) **Physician** HEMORRHAGE PULMONARY /Medical Due to (or as a consequence of): Examiner PREMIATUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed WEIGHT EXTREME BINGH wa for use as the burial-trar Due to (or as a consequence of) resulting in death) Last physician RESTRICTION BUIRBUTERINE attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) pac 1 Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has N autopsy page 2 performed After this certificate 1 □ Yes 2 **V**No 2 No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. Box 68760, of Vital Records, or Attending Division after death filled in by within 24 hours a

To the Funeral I

completely filled

Maryland 21215-0036

Baltimore,

State Registrar JANRI

29b. Signature and title of certifier

(Check only one)

150 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 2010 Lorelie Mary Schultze August 8:35 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7323 Windsor Mill Road Baltimore 5. Social Security Numbe Unk | 6. Sex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 21, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 1930 Director 79 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Madical Expression at the redified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director 1 ☐ Yes 2X ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7323 Windsor Mill Road 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry un15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 110k Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Hughes - friend 302-B6 Stevenson Lane; Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5點Other (Specify) in state Signature of Funeral Service Lice ROTA 11 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 Part 1. It ter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** occurde 1000VG /Medical Due to (or as a consequence of): Examiner ænlipiden Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
a Funeral Director: After this certificate has been signed by the attending physician and burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Ves 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State of Maryland /	Department of Health and Mental Hy Certificate of Death	ygiene Reg. N2 0 1 0 2 7 1 3 4
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Death 3. Time of Death Day Year
/Medical Examiner	Helene Shelton 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	17,2010 8:37 A M 4c. County of Death
LAMIIIIIEI	LEVINDALE	BALTIMORE birthdayl If Under 1 Year If Under 24 Hrs. 8, Date of B	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 ▼ F 7. Age (In yrs. last 1 M 2 ▼ F 64	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 2	Day, Year) Country)
rland ow at	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	10d. Inside City Limits
e Many 3a-f sh tiffied a	MD Baltimore Gwyr	nn Oak	1 □Yes 2X No
Ifer death with the Mau Ifer death with the Mau Inner must be notified Funeral Director	10e. Street and Number 4003 Buckingham Road	10f. Zip Code 21207	10g. Citizen of What Country? USA
or same	11. Marital Status 1	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
ed within 72 houygiene. ygiene. "natura ier than "natura t, the Medical E. Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk	6a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry UTT
I yidilid Zizi	17. Father's Name (First, Middle, Last) UIIK	18. Mother's Name (First, Middle	le, Maiden Surname) unk
ire, wally is 1 and 2 shoul of Health and M item 27 is marl other traumati	19a. Informant's Name/Relationship (Type. Print) Loretta Carter - caregiver	9b. Mailing Address (Street and Number or Rural Route Num 4003 Buckingham Road; Gwyn	
Dalumore, permit. Pages 1 s Department of He mportant: If item nny injury or other nnee.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State	e of Disposition (Name of Date stery, crematory or other place)	20c. Location - City or Town, State
permit. Departr Importa any inji	21. Signatus Funeral Space Licensee	22. Name and Address of Facility State Ana 655 W. Baltimore Street	; Baltimore, MD 21201
Physician	23a. Part LEnter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line. Immediate Cause (Final	On not enter the mode of dying, such as cardiac or respiratory ARTERY DISENSE	arrest, Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Carlies (Final disease or condition resulting in death) a. CORDWARY Due to (or as a conse were		
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	ne att):	
cate be executed physician and the burial-transit calcal Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of the con	ce of):	
ertificate be ing physicial e as the bur	IF FEMALE:		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death	ath 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
law requires that as been signed b 2 should be deta	I INIEN TEN CLOS	g a g g g	d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown
The law required has been so page 2 should			topsy prior to completion of cause of death?
Sician: Sician: Certificat	25. Was case referred to medical examiner?	26. Place of Death (Check only (Outpatient 3 DOA Other: 4 Nursing Home 5 Re	
ding Physical After this of funeral direction: To	27. Manner of Death 1	4 Nursing Home 5 Re	esidence 6 Other (Specify) e how injury occurred
tral or Attending First after death. ral Director: After led in by the funer. Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office 28f. Location	(Street and Number or Rural Route Number, rown, State)
o the Hospita ithin 24 hours the Funeral ompletely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and due to the and/or investigation, in my opinion, death occurred at the time.	he cause(s) and manner as stated. he, date and place, and due to the cause(s)
To th withir To th comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23	DD063327	08/17/2010
	GIZAW WOLDETHUCT, MD, 2434 W	1. BELVENERE AVE, BALTIM	ORE, MD 21215
State Registrar	GIZAW WOWDETHWOT, MD, 2434 W 31. Date filed (Month, Day, Year) AUG 30 2010	parl	

DHMH 17 Rev 1/2001

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year ^o Physician STONE 12:20A TERN 25 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Friends Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔯 F Director 160-24-2812 98 Yrs Dec 15. 1911 Conneticut Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show items 23s or 28s-f shov MD Director Montgomery 1 Yes 2 No Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17340 Quaker Lane 20860 USA Completed by Funeral should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status treumatic event, the Medical Examiner 1 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced naturel 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) librarian education other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F is marked of Frank Philip Stowe Sarah Stowe 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Linda Looney - niece 439 Manchester Street; Manchester, NH 03103 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any njury or once. ' 4 ☑ Donation 5 ☐ Other (Specify) 21. Si natu + 1 Funeral S rvice Licenses Na. 1 d S W 22. Name and Address of Facility State Anatomy Board Director in 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician LNANITION /Medical Due to (or as a consequence of): **Examiner** CANCER LIRETER 10 monsty if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) MARY TORVETIVE PULMENARY Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit 1420M1C that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician DEMEN Physician/Medical 4 FH SS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ρ Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be BENTEHSION 1 Yes 25 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 20 No 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 1 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 5 SPRING, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20905

Registrar DHMH 17 Rev 1/2001

State

JOHN E. GLAN

31. Date filed (Month, Day, Year)

MD

legistrar's Signature

1731 BRIGGS CHANGY ROAD

MARTLAKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 2010 11:32 A M **Physician** Henry Evans Smith Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 215 Club Road 8. Date of Birth (Month, Day, Jan 15, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Months Hours 1 ☑ M 2 ☐ F 219-01-7519 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminary. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10h County 1X Yes 2 □ No **Funeral Director** Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21210 215 Club Road 12. Was Decedent Ever in U.S. Armed Forces? 1 四Yes 2 □ No 1941- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 M Married white 1 ☐ Yes 21 No If Yes, Give Year or Dates: Specify: þ Specify: 1946 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) banking mortgage banking unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Morrow Henry Evans Smith Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beechmere Lane; Cockeysville, Maryland 21030 John Scott Simpson - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 □ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral School regtor 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) B **Physician** omce years 0 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No 2 UNO 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 2 No 1 Yes neral Director; A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier amava 5 201

State Registrar mill

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Jeanne L. Shiptisky 2010 2:58 AM <u>August</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2110 Ganton Green #205 Woodstock <u> Howard</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1928 Months 1 □ M 2 🖸 F Maryland 81 Director 217-26-9443 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Expunits must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Woodstock MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21163 USA 2110 Ganton Green #205 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4or 5+) Elementary/Secondary (0-12) Social Services secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Woff Lena Brodsky ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Shiptisky - husband 2110 Ganton Green #205; Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Foard Funeral Service ROII3 Director 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate C Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760. physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print) Millen NVO. State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Items 23art 11,25,27,28a-T per me, g913,03/25/2011 dmb

			1 - State Registrar	,27,28a-f	per me, g91. tificate of Dea	3,03/25/2011 The ath	2010 27138 eg. No.
	Physicia Medic		1. Decedent's Name (First, Middle, Last) John Dominic Torre			2. Date of Death	h 29, ^{Day} 2010 Year 7:50 А. м
	Examin		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Loc Balt:	cation of Death	4c. County of Death N/A
	Funeral Director		214-14-7653 1 M 2 🗆 F	90 Yrs.		Under 24 Hrs. 8. Date of Birth ours Min. (Month, Day, February	9. Birthplace (State or Foreign 26, 1920 Mar yl and
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town or Loc	cation imore		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	vith the M. 23a or 28 st be noti		10e. Street and Number 5934 Theodore Avenue		10f. Zip Code	1214	0g. Citizen of What Country?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	l II	Vas Decedent of Hispar f Yes, specify Cuban, M ☐ Yes 2 ☐ No S	nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "nat , the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or secondary 2)	(Give k	lent's Usual Occupation kind of work done during O NOT use retired) Service	g most of working	16b. Kind of Business Industry BG & E
yland	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Dominic Torre		18.	. Mother's Name (First, Middle, M Anna Catanes1	alden Surname)
, Man	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Catherine G. Torre/ Wife	19b. Mailin 5934	g Address (Street and I Theodore Ave	Number or Ryral Route Number, Nue Baltimore Mary	City or Town State, Zip Code) y Land 21214
imore	nit. Page 1 a artment of h ortant: If ite injury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispose cemetery, crem Parkwood Co	sition (Name of natory or other place) emetery	9/2/10	20c. Location - City or Town, State Baltimore Maryland
Balt	permit Depart Import any inj	Ų	21. Signature of Funeral Service Licensee	22. L	. Name and Address of eonard J. Ruc	k, Inc. Baltimore	ford Road e, Maryland 21214
	Physician/	ē 19	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)	ıch as cardiac or respiratory arres	st, Approximate Interval Between Onset and Death		
مسبيدا	Examiner	er	Sequentially list conditions	a consequence of):			K a the star
	ecuted and Il-transit	Examiner	cause, Enter Underlying Cause (Disease or linjury that initiated events c	a consequence of):	1	ACA APPROVED BY MEDICAL	EALINER O
3760	icate be executed g physician and is the burial-transit	edical	d		CERT	IFICATION APPROVE	
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P.O	quires that the consigned by the consigned by the details only be detailed.	by	Part II. Other significant conditions contributing to death b Shoulder Dislocation	ut not resulting in the ur	nderlying cause given ir		acco use contribute to the cause of death?
Shoulder Dislocation							
Vita	hysician nis certifi I director	To Be	25. Was case referred to medical example? 1 Yes 2 No. Hospital: 1 Inpati	ent 2 ER/Outpatient	Other:	of Death (Check only one) Nursing Home 5 Resider	nce 6 Other (Specify)
on of	al or Attending Pl s after death. Il Director: After th ed in by the funeral	Certificate:	27. Manner of Death 1	, Year) injury	28c. Injury at work? 1 Yes	located	vinjury occurred Subject dis- shoulder while using ls in bed.
Divisi	tal or Att rs after d al Directo led in by t		building, etc	iry - At home, farm, stre c. (Spec <i>ify)</i> ng Home	et, factory, office		eet and Number of Bural Route Number State) 6040 Harford Road
	the Hospi iin 24 hou the Funer	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of each only one) 3 Certifying Nurse Practioner: To the	xamination and/or investi	igation, in my opinion, de	eath occurred at the time, date and	place, and due to the cause(s) and manner stated.
	vitt To T		29b. Signature and title of certifier M	D	29c. License num		d. Date signed (Month, Day, Year)
+	(30. Name and address of person who completed cause of de Mittal Payagat 881	eath (Item 23a) (Type, Pr 3 Waltho	rint) Am Woods	Rd, Parkerella	2 MD 21234
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17 per Th \$907 9-7-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year August 27, Physician/ Farl Jerome Thomas Jr. 3:30 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Rehabilitation Center PG Clinton 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ፟፟፟ M 2 ☐ F Funeral 212-28-2806 Months Hours 09-30-1940 Maryland 69 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NC Whitakers 1 🗆 Yes 2 🛣 No Nash 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 300 W. Taylor St. 27891 USA #6A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Naval Ordinance Station Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathe To Name First, Middle, Last) ပ္ Thomas Sr. Elizabeth Dyer 19a. Informant's Name/Relationship (Type, Print)

Cynthia Thomas/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 W. Taylor St. #6A Whitakers, NC 27891 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Church Cem. 9-4-2010 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Pomfret, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Lige 10583 Middleport Ln. White Plains, MD 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last Dementia the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 XNatural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD036400 08/27/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving St. NW #201 Washington DC 20010 Gordon Ramsav 31. Date filed (Month: Day, Year,

DHMH 17 Rev 7/2009

State Registrar

AUG 3 0 2010

10-06474 Albert W Urban Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0824 hrs **Medical Examiner** August 27, 2010 Urban Albert Walter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours 1 X M Director Country)Maryland 216-60-7057 2 F 58 09/08/1951 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Pepartment of Health and Mental Hygiene.

nportant: If item 27 is marked other than "nature!"
iury or other traumatic event. 1 Yes 2 X No 23a or 28a-f show notified at once. Maryland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 101 Prospect Avenue U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: White Specify: 4 Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Firefighter 11 Anne Arundel County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Be Albert William Walter Urban Florence Kinsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Joyce G. Urban (Wife) 101 Prospect Avenue Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State |08/31/2010 Glen Burnie, Maryland Glen Haven Mem. Pk. 4 Donation 5 Other Specify: ²² Name and Address of Eaglity McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Edneral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease complicated by Immediate Cause (Final disease Examiner or condition resulting in death) oxycodone intoxication Due to (or as a consequence of): Sequentially list conditions Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and trar hysician/Medical X AMENDED 3a, 27, 28a-f, per ME g910 12/6/10 TT the attending physician ned for use as the burial UNPENDED 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o <u>\$</u> 1 ✓ Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease Completed Records, has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes page ✓ Yes 2 No 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, of Vital examiner? Other₄ Nursing Home 5 Residence 6 Other this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death -1 -Natural Division Pending 1__Yes 2_XNo Director: death. Fd 8/27/10 Fd 7:44 am Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 Prospect Ave Glen Burnie, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide (Specify) Found: residence determined hours a 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 28, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yea istrar's Signature State Registra

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Dav Month 8:35 AM M Jorene White August 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 3810 Ferndale Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Hours Days 1 □ M 2 🔀 F 218-56-2192 58 Nov.18,1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 □ No Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3810 Ferndale Avenue 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder 8 Shipyard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James White Mozelle Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 Willie Mae Quince 817WestSaratogaStreet, Apt. 2, Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-30-10 Hanover, Maryland ArdentCremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the jonce.

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Director

Funeral

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Completed

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filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Examine

Physician/Medical

Be Completed by

Certification: To

Medical

sician and burial-trans attending physician for use as the buria signed by the a be detached f icate has been si page 2 should b director,

Division of Vital Records, P.O. Box 68760

1 □ Yes 2 D No 9 □ Unknown	9
Part II. Other significant condition	
25. Was case referred to medical examiner? 1 ☐ Yes 2 N No	Hospi

					1 □Yes 2 ■No	1 ☐ Yes 2 ☑ No					
25. Was case reference examiner?	rred to medical		26. Place of Death (Check only one)								
	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ □	OOA Other: 4 - Nursing F	Home 5 Residence 6 [☐ Other (Specify)					
27. Mann Dea 1 Vatural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury of	occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		ome, farm, street, facto	ry, office	28f. Location (Street and a City or Town, State)	Number or Rural Route Number,					
29a. Certifier (Check only		hysician: To the best of my knominer: On the basis of examination									

(Check only one)
29b. Signature a

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4538 EDMONDSON Are BATMD Date filed (Month, Day, AUG 3 0 2010

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year WHITE IANNA 19:30 08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MARYLAND ENTER If Under 1 Year If Under 24 Hrs Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min. (Month, **Director** Usual Residence of Decedent 10c. City, Town or Location or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No timore 10f. Zin Code 10e. Street and Number 10g. Citizen of What Country? Funeral venue nah 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed 1ac 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use petired)
 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 00 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once, be traumatic 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21216 IMUSE Baltimore, Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City of Town, State 1 Burial 2 Cremation 3 Removal from State emetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) timore, MD Signature of Funeral Service Ligensee Laughn 22. Name and Address of Facility Greene Funeral Services Kuad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ EREBRAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SPIRATORY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed COPD attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗷 N 2 XNo Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

filled in by the funeral director, within 24 hours a

To the Funeral C

completed filled

only one)

286

29b. Signature and title of certifie

AUG 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASSMANA

Registrar DHMH 17 Rev 7/2009

State

22

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

21201

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS. G907.9/17/2010 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Beulah E. Wolfe 2. Date of Death 3. Time of Death Physician/ 11:55а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Elternhaus Howard Dayton Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 □ M 2 □X= Days Director ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho minortant: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15513 Wembrough Street 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: white 3 M Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Hollenbeck Gertrude Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Pinnick (daughter) 15513 Wembrough St., Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Shepherd Mem. Park 9-1-10 Hendersonville, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herber Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence oil Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRIDIUM DE 1 (1 1 2 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature 29d. Date signed (Month, Day, Year) 8 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Dailinge, Maryland 21213-0030		٠	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland		4.	
Department of Health and Mental Hygiene.	Fi Di	PI	- 7
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	Medic	al	Robert Alvin Whi 4a. Facility Name (If not institution, giv.					August		5:26 P M
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	Funeral		Gilchrist Center 5. Social Security Number 6. S		rs, last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		O Birthplace (State or Foreign
	Director		501-01-5748 Usual Residence of Decedent	Ø M 2 □ F 9	4 Yrs.	Months Days	Hours Min.	July 28	, Year 1916	Nebraska
	permit. Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County	10c.	City, Town or Loc	eation			_	10d. Inside City Limits
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:	3a or	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
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9	illed within 12 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Be Completed by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No	I	Vas Decedent of His Yes, specify Cuban		Rican, etc.)	Black,	White, etc.
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Maryland 21215-0036	should be fill and Mental is marked of aumatic eve		19a. Informant's Name/Relationship (Type, Print)	I	g Address (Street ar			-	
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Baltimore,	gela ntofH : If ite or otl		20a. Method of Disposition 1 🕅 Burial 2 🎧 cremation 3 [Removal from State	b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date		ity or Town, State
tin.	rr. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Oher (Spec		oreland			/2010	Baltimor	
Ba	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Fuller Service Co.	Cen		. Name and Address UCK TOWSO	-	1 Home		ork Road , MD 21204
	Ť.		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the d					est,	Approximate Interval Between
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Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preduced 1 Live Birth 2 If 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mont	·
m -		Physician/N	1 Yes 2 No 9 Unknown	9 Unknown	ordeath 5 L	Other (specify)				
P.0	ned by deta	y Pi	Part II. Other significant conditions						bacco use contrib	ute to the cause of death?
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Sorc	as bee	plet	Sirve djo.					24a. Was a		ere autopsy findings available or to completion of cause of
Rec	ate ha	Completed by						perfor		ath? ☑ Yes 2 ☑ No
tal	ertific setor,		25. Was case referred to medical examiner?	Hoenital:			ce of Death (Check	k only one)		
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isio	ar dear	rtifi	3 Suicide 6 Could not l	28e. Place of Injury - A	y - At home, farm, street, factory, office 28f. Location				(Street and Number or Rural Route Number,	
Division of Vital Records,	al Dire		building, etc. (Specify) City or Town, State)							
1	Funer Funer Fed fill	Medical	(Check 2 Medical Exam		ation and/or invest	igation, in my opinior	n, death occurred at	the time, date ar	nd place, and due to	o the cause(s) and manner stated
-	o the	Me		rse Practioner: To the best o			time, date and place	e, and due to the		ner as stated.
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			30. Name and address of person who	completed cause of death (I	tem 23a) (Type, P	rint)	10635		8/CU/1	<u> </u>
			30. Name and address of person who (avm Putt (31. Date filed (Month, Day, Year)	completed cause of death (I	Charl-	rint)		nove f	10 200	204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 August 16 7:10 A M James Whiting Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Davs Hours Min. Aug 20° 1941 Washington DC Director 185-32-1863 68 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d Inside City Limits Director MD Prince Georges Clinton 1 ☐ Yes 2 X No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 20735 9211 Stewart Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 K No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) enterprenuer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Whiting Sr. Gloria Carter 19a, Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10403 Thrift Road; Clinton, Maryland 20735 Francine Frazier - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final neuMD119 Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a sunsequence of; Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 5 Other (specify) been signed by the a should be detached t Other significant conditions contributing to death but not resulting in the underlying cause given in Parts
HYDECTEN STORES OF THE STORES OF T 23e. Did tobacco use contribute to the cause of death? Completed by eshur 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျှ 1 🗌 Yes 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar SYLVESTER OKONKWO

AUG 30

7 Day, Year) 3 0 2010

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SYLVESTER OKONKWO, 6191 OXON ITH RD, SOF, OXON HILL, MD 20745

D0055314

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Funeral Director

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ner	4a. Facility Name (If not ins		e street and nu	ımber)		4b. City, Town, Owing					inty of Deat	
	230 Hopkins 5. Social Security Number	Lane 6. S	av	7. Age (In yrs.	last hirthday)	If Under 1 Year			8. Date of Birth			hplace (State or Fo
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rec	10e. Street and Number					10f. Zip Code			1	0g. Citizen	of What Co	untry?
0	230 Hopkins	Lane	2			2111	7			USA		
Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic	Origin? (Spe	cify Yes or No-			rican Indian,
/ Fu	1 ☐ Never Married 2 ☐	Married	Armed Fo 1⊈TYes If Yes, G	2□No 194	.3-	ni res,specily Cu 1 ∐ Yes 21∑ No			nican, etc.)	1	Black, White e <i>cify:</i> wh	
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ပို	17. Father's Name (First, M	iddle. Last)			CAC	Cacivo	18. Mo	other's Name	(First, Middle, I			
To Be	Charles Samuel Walsh Ann Lewis Guest							,				
To Be Completed by Funeral Director	19a. Informant's Name/Rel	ationship (Type. Print)		19b. Maili	ng Address (Stree	et and Nur	mber or Rura	I Route Number	; City or To	wn, State, 2	Zip Code)
	Annette W.			daughtei	l	-						
	Annette W. Bergsma - daughter 723 Jamestowne Road; Sleepy Hollow, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20c. Location - Commenterly, crematory or other place)									on - City or	Town, State	
	4 ☑ Donation 5 ☐ Other (Specify)										1	
	21. Signature of Funeral Service Livensee Ronald S. Wade Darrector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 2120											
	23a. Part 1. Let ter the disas, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ot heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									8	Approximate Interval Between Onset and Deatl	
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2	1 Yes 2 No		Hospital: 1 🗆	Inpatient 2	ER/Outpatier	nt 3□DOA Of	ther: 4 🗆	Nursing Hon	ne 5 Reside	ence 6 🗆	Other (Spe	cify)
ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 Natural 5 Pending (Month, Day, Year)						3c. Injury at Work? 1 ☐ Yes 2 ☐ No					
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)								ımber or Rı	ural Route Number,		
Medical C	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Ph dical Exam	niner: On the b	e best of my kno casis of examina nner stated.	owledge, deat ation and/or ir	h occurred at the vestigation, In my	time, date opinion, o	and place, a death occurre	and due to the c ed at the time, d	ause(s) and ate and pla	d manner as ce, and due	s stated. e to the cause(s)
	29b. Signature and title of c	ertifie	<u> </u>	,		29c. Licer	nse numbe	er	2	9d. Date si	gned (Mont	h, Day, Year)
Me	/1 _ // /					1			1			
Me	29b. Signature and title of certifier William Company (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 08 - 24 - 201											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wolfe Donald 23 2010 Womer August 22:06 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8213 Cornwall Road Dundalk Baltimore If Under Funeral 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours 1 X M 2 - F November 17, 1928 Director 81 213-26-3957 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8213 Cornwall Road 21222 USA or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 X Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Laborer Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Franklin Wolfe Marjorie Melissa Womer and 2 should be Health and Mereten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen M. Wolfe wife 8213 Cornwall Road, Dundalk, Maryland permit, Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 27. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2010 Baltimore, Maryland 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 2110 Collers Point Road, Dundalk, MD Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician, PROSTATE CANCER yenag METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, i or Attending Physician: B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: 은 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HEMATOLOGIST D-51555 08/24/2010 ONCOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

SEIN AUNG,
31. Date filed (Month, Day, Year)

AUG 30

9103 FRANKLIN SOUARE DRIVE # 2200, BALTIMORE, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Reed Yox OZU AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death itu Baltimore Hospita Timore Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 3 M 2 ☐ F Months Hours Min. Country)
MD 214-46-9015 64 Director Vrs 946 Usual Residence of Decedent 10b. County or 28a-f show 10a State filed within 72 hours after death with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD Baltimore Co. Owings Mills 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1118 Kingsbury Rd 21117 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces
1 X Yes 2 Black, White, etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🔀 No Specify: If Yes Give "natural", Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation fand 21215-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 mechanic Factory other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be.
Department of Health and Mental Important: I frem 27 is many injury or other. be f ည Grover Yox Dorothy Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ping L. Yox 1118 Kingsbury Rd, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem 8/30/10 Owings Mills, MD Signa are of uneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. motostati or cinoun disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): cal Division of Vital Records, P.O. Box 68760 Physician/Medi yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year signed by the aid be detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗀 Yes 3 Probably 4 ☐ Unknown 2 🗌 No 24b. Were autopsy findings available 24a. Was an has autopsy performed prior to completion of cause of death? eral Director; After this certificate filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Movvin Feldman Baltimore, Md Mn 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:50 A M Month Physician/ 0 Zycker rugust 201 Irwin Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 213-34-5293 **Funeral** Hours 1**X** M 2 □ F 75 Months 129717771934 MD Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b County 10c. City. Town or Location 10a. State Funeral Director must be notified XX Yes 2 No MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 5023 WETHEREDSVILLE ROAD 21207 23a **USA** ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 X Married ☐ Yes 2X☐ No Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) MD STATE ROADS Hygiene. life. DO NOT use retired) College (1-4 gr 5+) Elementary/Seconday (0-12) MATERIALS ENGINEER COMMISSION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F 27 is marked o traumatic eve ည JOSEPH ZUCKER SARAH ZIGLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ELLEN BROOKE / WIFE 5023 WETHEREDSVILLE ROAD BALTIMORE, MD 27 or other Baltimore, 20a. Method of Disposition

1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 8/27/2010 REISTERSTOWN, MD 22. Name and Address of Facility of Furieral Service License SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD Por 1. Enter the disease, sement ations that cause who death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Par 1. Enter the disease Onset and Death Immediate Cause (Final disease or condition Physician/ Stomach Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical death certificate be Box 68760 attending p IF FEMALE: for use a 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death ed by the a P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗹 No 3 Probably 4 Unknown 1 Tes Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has li irector, page 2 s autopsy performed?
Yes 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital 4 Nursing Home 5 Residence 6 D Other (Specify) Other: 2 🗷 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation
6 Could not be within 24 hours after death To the Funeral Director: / completed filled in by the i 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0057465 8/26/10 ns Rajapame M.D

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

AUG 3 0 2010

235 Smith Av , 5-235, Baltimore, MD. 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1- State Registrar #7, F. Home, 8/17/10, E.T, Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean M. Aspinwall Month 8 Day 13 2010 9:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11606 Gum Point Rd Berlin Worcester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 StF (Month, Day, Yea, 13/1920 Months Days Hours Min **Director** 188-20-9155 91 90 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Worcester Berlin 1 ¥ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11606 Gum Point Rd 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 R Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Harry Bruce Green Leola (Dunn) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 2...
Department of Health an Important: If item 27 is 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas L. Aspinwall/son 5879 Westville Rd Hartly, DE 19953 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Church of the Good 8/20/2010 Paoli, PA 21. Signature of vurious ervice Licensee 22. Name and Address of Facility 108 William St, Berlin MD Burbage Funeral Home 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALZHEILER'S STA66 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HEINE RIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown DECUBITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy (3) perform this certificate Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident Investigation 1 Yes 2 No 24 hours after deat Funeral Director: Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

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Registrar

State

31. Date filed (Month, Day, Year)

AUG 17

GONZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 AUG 13, 0410 Martha Ann Anderson М 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, SEP 20 Birthplace (State or Foreign Country) Days Hours Min. Months 1 □ M 2 F 057-09-1909 92 1917 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States 301 Russell Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Besida Stella Radovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John C. Anderson/Son 104 Park Ave. #209 Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/19/2010 Paramus, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Vander Plaat Memorial Home Rus M00956 S-113 Farview Ave., Paramus, NJ Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Usosepxus disease or condition resulting in death) Due to (or as a onsequence of): Urinary tract infection (E, cali) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Liceace 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ficience 1 □ Yes 25. Was case referrexaminer? 26. Place of Death (Check only one)

Physician /Medical Examiner Examine Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner is ust by notified at once.

Baltimore, Maryland 21215-0036

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran funeral director, this

Physician/Medical

<u>۾</u>

Completed

Be

Certification: To

Medical

1∐ Yes

27. Manger of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

2 1 No

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

GAITHERSBURG, WID

1 L. Robert Der 30. Name and address of person who completed cause of death (thm 23a) (Type, Print) 201 RUSSELL 4-VENL

04115

14. ROBERT BIRSCHBACH, NLD 31. Date filed (Month, Day, Year)

State Registrar

16 2010

33. Registrar's Signature

To the Hospital or Attending Ph within 24 hours after death.
 To the Funeral Director: After th completely filled in by the funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ Terry Amos 20°10 12:15 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges District Heights 6826 Walker Mill Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Hours (Month, Pay Year) 954 South Carolina 579-92-5694 Director 56 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director District Heights Prince Georges MD 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 of Morard Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be 1 permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 20743 USA 6826 Walker Mill Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' 1 ☐ Yes 2 ☐ No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Chef. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Doretha McBride Herman Amos, Sr. Brother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Maher Court, Ft. Washington, MD 20744 Herman Amos, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 8-20-2010 Ressurection Cem Clinton, MD 4 Donation 5 Other (Specify) Ralph Williams, II Funeral Service, 5202 PrincetonsDelightDr., Bowie, MD P.A. 20720 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, HTN Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 🛛 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 4 hours after death. uneral Director: Aft ed filled in by the fun 1 🗆 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pany is pres MO

filed (Month, Day, Year)

AUG 1 7 2010

Andres Mendez-Munoz, MD

MD 32022

8/16/10

2100 W. Pennsylvania 034; '6th Wfloor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RONALD WAYNE BOSLEY :53 Aug Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Medical Center Bel Harford 5. Social Security Number 6. Sex 1 M 2 D If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Min Director 216-92-7161 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Harford Fallston MD. 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1309 Murgatroyd Road 21047 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?...
1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 8/22/10 0453 0 Baltimore, Maryland 21215-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pressman Baltimore Sunpapers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Bosley Sr. George Mary Nancy Messenger 19a. Informant's Name/Relationship (Type, Print) $({ t Father})$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 Bosley Sr Road Fallston. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 26, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Air, Mem. Gardens Bel Maryland 21. Signature of Funeral 3 of ice Vic 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home. P.A. Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an elech line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical $\beta o < je \omega$ Konglater P.O. Box 68760 Division of Vital Records, P.O. Box earthcate be the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for I in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy perform Yes completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Underlined Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Name and address of person who completed cause of death (Item 23a) (Type, Print) CW13 Who

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20ÎÎ Franklin D.R. Burcker August 11:21 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington NMS Health Care Hagerstown . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec • 3I 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F Mary Land Director 212-38-9338 70 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2X No MD Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11824 Paden Ave. 21783 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X** No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med County life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Heavy Equipment Operator Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic Raymond Francis Burcker May Lillian Virginia Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Jeannette M. Thompson/Daughter 1162 Outer Dr., Hagerstown, MD Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park ! 8/24/2010 Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-translt Jause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown plnods Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 in the funeral director. autopsy performe 2 🗌 No Yes 2 X No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ပ္ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

State

AUG 30 Registrar

29b. Signature and title of certifier

Dernanue

Stephanie Comer-Concordia CRNP 14014 Marsh Pike, Hagerstown, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

R125748

29d. Date signed (Month. Day, Year)

August 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 25 per phys. G907 9/1/10 dk.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 20 TO Francis Balling August 3:55a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Elkton Ceci1 5. Social Security Number If Under 1 Year 7. Age (In vrs. last hirthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days 1 👿 M 2 🗆 F Hours July 10,1916 Director 182-09-6123 94 Yrs. DE Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 ▼ Yes 2 No MD Ceci1 E1kton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 19 Leedom Rd. 21921 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyghen. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Painter House Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Nurnberg John Balling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga K. Sullivan / wife Leedom Rd. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8/1972010 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Immaculate Conception Cemetery Elkton, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Foard and Gee E. Main St. Elkton, MD 21921 23a. Part 1. Enter the disease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, chie disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Day Month Year 5 Other (specify) the 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? page 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 20c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGUST CHARLES 2010 OWEN BRANTNER 3:50A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 13€34M 2 □ F Days Hours Aug 27, 1935 Mary land **Director** 74 Yrs 216-30-0211 Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Thurmont 28a-f 1XX Yes 2 ☐ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 108 Laurel Avenue 21788 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than "
event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) 12 Communications Manager Ft. Detrick Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever e 1 and 2 should be fil t of Health and Mental If item 27 is marked ပ Ira Brantner Anna Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Brantner 108 Laurel Avenue, Thurmont, Maryland wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o 1 M Burial 2 Cremation 3 Removal from State Resthaven Memorial 4 Donation 5 Other (Specify) 8-14-2010 Frederick, Maryland 21. Six ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home haron 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interv I Between Onser and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a conseque **Examiner** Sequentially list conditions. Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year as been signed by the a 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes မ patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Ustural 5 Pending work' death. Accident 1 Tes 2 No after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I e Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practiener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) MDD 16428 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come Casper Cline

State Registrar

4 HUA

DHMH 17 Rev 7/2009

Frederick, MD

300

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Day 13 ^{Year} 10 Brady Ruth McNeal Herring 1235p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Heartland House Grasonville Queen Anne's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Maryland Director 84 220-24-4614 Oct. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f sl Examiner must be notified 1 ☐ Yes 2XXX No Maryland Queen Anne's Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40 Prospect Bay Drive West United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates . Page 1 and 2 should be filed within 72 hours iment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert Quigley Herring Margaret Lee Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Song Sparrow Court, Arnold, Maryland 21012 John Brady - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date Chesapeake Cremation Center 1 Burial 2 X Cremation 3 Removal from State August 22 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, Maryland . Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 106 Shamrock Road, Chester, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ Failure disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hrs Fang Cerepio varcular, Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown tructive Pulmerian 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 🗌 Yeş 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) CARE HELLE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

dress of person who completed cause death (Item 23a) (Type, Print)

Registrar's Signature

Dawn Yvette Brooks 10-05886 P UNKUNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27158 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	C	ertificate of	Death		R	leg. No.	
Physicia ical Exami		1. Decedent's Name (First, Middle,Last Dawn Yve					2. Date of Dea Month August 6,	nth Day Year 2010	0308 hrs
		4a. Facility Name (if not institution, give 6841 Third Street	street and number)	4	4b. City, Town, or New Carrol	r Location of Death Ilton	n	4c. County o	
Funeral Director		5. Social Security Number 6. Sec. 214–86–7749 1	7. Age (In yrs	s. last birthday) 8 Yrs.	If Under 1 Year Months Day	ar If Under 24Hrs ys Hours Min	s. 8. Date of Bi	rth (MM/DD/YYYY) 1972 y 31,	9. Birthplace (State or Foreign Landover, Country)Maryland
w any		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Locati					10d. Inside City Limits
Maryland - 28a-f show	Director	10e. Street and Number	Georges	New Car	rollton 10f. Zip Code		1	l 0g. Citizen of Wha	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral Di	6841 Third Stre	12. Was Decedent Ever in Armed Forces?			4 spanic Origin? (S n, Mexican, Puerto		United S	American Indian, Black,
s after deat ral", or ite	þ	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	Yes 2 X No	specify:		Specify:	Black
W 2 -	Completed	15. Decedent's Education (Specify on: Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)	during mo	ost of working life	ation (Give kind of vote DO NOT use ret		Sherwood Center	od Day Care
uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last)	Brooks, Jr.	OHII	d dare	18.Mother's Name		Maiden Surname)	
d 2 should be tth and Ment n 27 is mark umatic ever	ToB	19a. Informant's Name/Relationship (Ty	pe, Print) (Mother)	T. C.	Address (Stree	et and Number or I	Rural Route Nur	mber, City or Town	
rmit. Pages I and 2 spartment of Health Iportant: If item 2 jury or other traus		20a. Method of Disposition 1 ABurial 2 Cremation 3	201	p. Place of Disposi crematory or oth	ition (Name of ce	metery,	Date . 13,2010	20c. Location - 0	City or Town, State
permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		4 Donation 5 Other Specify: 21. Signature of Funeral S. A ice Licens			ame and Address	s of Facility R.		ton Compa	Spring,Maryla
nysician		23a. Part I. Enter the disease, or complifailure. List only one cause on each							t Approximate Interval Between Onset and
xaminer			Multiple Gunshot Wou ue to (or as a consequence						Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
cuted and transit	I Examine	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence	of):			•		
icate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED 23c. If yes, outcome of pre	egnancy				23d. Date of c	elivery
ath certif attending or use as	sician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown	1 Live birth 4 Pregnant at time of	2 Fet	tal death 3 ner (Specify)	Ectopic pregna	ancy	Month	Day Year
s that the de gned by the e detached f	by Phy	Part II. Other significant conditions		t resulting in the u	nderlying cause (given in Part I.			ute to the cause of death?
hysician: The law requires that the d this certificate has been signed by the director, page 2 should be detached	Completed							psy pri rmed? de	ere autopsy findings available or to completion of cause of ath?
ian: The certificate ctor, pag	യ	25. Was case referred to medical examiner?			26 Place	e of Death (Check		2 No 1	Yes 2 No
ng P	n: To B	1 Yes 2 No 27. Manner of Death	28a. Date of Injury FOUND:	28b. Time of In	njury 28c. Inju	Other Nursin		Residence 6 V	
l or Attendi after death Director: d in by the f	Certification:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	Aug 6, 2010	FOUND: 0306 hrs home, farm, stree			28f, Location (Street and Number	or Rural Route Number, City
The state of the s									s stated.
Hospi 24 hou Funer	ଞ୍ଚା	one) a Medical Examiner:	On the basis of examination	and/or investigati	on, in my opinion	n, death occurred a	at the time, date	and place, and du	e to the cause(s)
To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
Hospi 24 hou Funer			manner stated.					29d. Date signed August 6, 20	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 per FD AACO Health Dept 8-12-10 KAH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month of 0620 M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral **4** 2 □ F Days Hours Min NOV 28 428-34-8437 1926 Mississippi 83 Director Usual Residence of Decedent show 10b. County 10c, City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Anne Arundel Marvland Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 506 Royal St. 21401 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black White etc. 1 Never Married 2 Married "natural", or Š Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1963 – 66 1 ☐ Yes 2X No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Worker Ft. Meade Army Post 12th 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Benson Fannie Brason Benson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Carpenter(Daughter) 506 Royal St. Annapolis, Md. 21401 Baltimore, 20b. Hace of Disposition (game of cemetery crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 8-14-10 Annapolis, Md. MMame Backer Collinsons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lavy 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 'Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran resulting in death) Last attending physician Physician/Medical that the death certificate be as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Vear 5 Other (specify) 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform yes 2 2 No certificate 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Phopatient 2 🗆 မ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check The decidence of the past of examination and a state of the state of t only one 29b. Signatu 2 8HVA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27160 State of Maryland / Department of Health and Mental Hygiene2010State Amend#20b PerFHPGC8-23-10cm Registrar Amend 19a, 20b PerFHPGC8-17 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ August 10, 2010 Randy Sean 1718 Brown М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Chever1v Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last hirthday) If Under 24 Hrs. 8. Date of Birth If Under 1 Year **Funeral** 1 🖾 M 2 🗆 F (Month, Pay, Year) 982 Months Days Hours Min Director Yrs Feb. DC 28 578-08-3972 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143 47th Street NE 20019 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) none none Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Jannie Plowden Reginald Brown, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 47th Street NE Washington, DC 20019 Reginald T. Brown/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Units 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/25/2010 Lee's Crematory Clinton, Maryland 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 10 yrs Chronic Respiratory Failure Medical Due to (or as a consequence of) Examiner 10 vrs Chronic Asthma Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Cunito (or as a consequence of signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Obstructive Sleep Aphea 10 yrs that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Down's Syndrome 22 vrs Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٤ Morbid Obesity 1 🗆 Yes 2 🔀 No 3 🗆 Probably 4 🗀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital ျ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical 1 Efertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my intelledge, duette accumed at the time date and plane and due to the nausely) and manner as state within To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aur) August 12, 2010 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) 164/ Richard Ashby, MD Benning Road NE Suite 301 Washington, DC 20002 32. Registrar ignatu State

DHMH 17 Rev 7/2009

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death РМ 2010 Catherine Carolyn Cobb August 1255 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci1 Union Hospital E1kton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🕅 F 221-58-9646 SEPT 12, 1966 California 43 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Apple Lane 21921 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gregory G. Cobb Debra Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Cole, III/Fiancé 11 Apple Lane, Elkton, MD 21921 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 24, R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2010 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multi system Immediate Cause (Final 01 disease or condition resulting in death) Due to (or as a consequence of): e patorenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 14travesev140 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No flecholism 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, certificate After this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral (

Physician

/Medical

Examiner Physician/Medical ð Completed Certification: To

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Exp. timer must be notified at once.

3altimore, Maryland 21215-0036

/Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

6 ☐ Could not be 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 red

29a. Certifier

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

40

106

and manner stated.

Registrar DHMH 17 Rev 1/2001

State

Bow Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OS 2010 18 0520 Vivien Averil Corbin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Center Allegani Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛣 F Min. Oct. 4, 1921 Months Hours England 88 385-48-0482 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Mineral Burlington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Rt. 1, Box 88-H 26710 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 💢 No 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Year or Dates Specify 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Albert Gardiner Marian A. Gardiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Springer/Daughter Box 188-H Burlington, WV 26710 August 21 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2010 4 Donation 5 Other (Specify) Green Spring, WV Glen Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Lice Smith Funeral Home Burlington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final 70 semochans disease or condition resulting in death)

Physician/ Medical Examiner

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24 hours after death. Funeral Director: After this certificate

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Certificate:

Physician/

Medical

10a. State

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Examiner

Funeral

Director

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death

72 hours after

Maryland 21215-0036

Baltimore,

P.O. Box 68760 requires that the death certificate

Division of Vital Records,

Physician:

Hospital or Attending

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permit. Page 1 Department of Important: If it any injury or o

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Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

25. Was case referred to medical

2 No

examiner?

27. Manner of Death

IF FEMALE:

c. —	Due to (or as a consequence of)
d	

Due to for as a consequence of

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death 9 I Inknown

3 Ectopic pregnancy 5 Other (specify) ____

Month Day 23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

1 Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform

2 X No

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

RACT INFECTION

				26. Place of Death (Check only one)							
ospital:	1 patient 2	☐ ER/Outpatient	3 🗆 (DOA	Other: 4 Nursing H	lome 5	Residence	6 ☐ Other (Sp			
	28a.	Date of injury	28b. Time of		28c.	Injury at	28d. De	scribe how inju	ry occurred		

Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

28f. Location (Street and Number or Rural Route Number City or Town, State)

29a. Certifie 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Dav. Year)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12502 Robert Welik, _Willowbrook Road

Cumberland, MD

19

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1540 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St HUSDILL allawa HOUSE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year) 79 **Director** 26 .358 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9940 20772 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) penter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Elsie Louise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 75 HAE John son Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 🛎 Burial 2 🗌 Cremation 3 🗔 Removal from State -25-4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuseral Service Licensee 22. Name and Address of Facility V1004 Mecha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and Lause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗆 No 1 Tes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pendina work? 1 🗌 Yes 2 🔲 No Investigation Accident 3 Sulcide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practioner To the basis of my limited by death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the inly one 29b. Signature and tit 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

31. Date filed (Month, Day, Year) **AUG 3** 0 2010

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician Joseph August 9, Moore Coogle. Jr. 5:10 D M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health and Rehab Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 13, 1 7. Age (In yrs. last birthday) If Under 1 Year | Il Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 403-40-2811 **X** M 2 □ F Months Days Hours Min 77 Director 1933 Kentucky Usual Residence of Decedent 10a. State Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at Anne Arundel Annapolis Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 River Drive 21403 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Executive Vice President Advertising permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked oth-any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Moore Coogle, Sr. Dorothy Virginia Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryhelen Coogle/wife 44 River Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Qurial 2 Cremation 3 Removal from State Cave Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 8/14/2010 Louisville, Kentucky 21. Signature of Juneral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending use a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by The law requires that Part II. Other significant apriliations contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 🗌 No 3 Probably 4 nown Completed been Mere autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed' 1 ☐ Yes ai 🗆 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 44 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To 1 🗌 Yes sing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 ____atural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Accident the 1 Girector: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Lire 1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

50 Name and address

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#31 PerVRPCC8-17-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Crayton 2010 8:50 August 6, AΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate House 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 124-16-5581 1 □ M 2**X** F Months Days Hours Min Mt. Airy, NC 4-15-1911 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bowie MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral with United States 20716 15013 Nighthawk Lane hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give than "natural", Specify: Black Completed 3 ♥ Widowed 4 □ Divorced Year or Dates event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any njury or other traumatic event, the Mone. Elementary/Seconday (0-12) College (1-4 or 5+) Saks 5Th Avenue 12 Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ethel Beamer Gwyn Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15013 Nighthawk Lane Bowie, MD 20716 Beverly J. Stephenson (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/16/2010 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician a. Myocardial infarction
Due to (or as a consequence of): Medical resulting in death) Examiner Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Dehydration death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Ves 2 No fo Month Day Year Pregnant at time of death Other (specify) signed by the a d be detached for Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Senile Dementia Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 X No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence $X \square$ Other (Specify) Hospice 1 Tes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral . Manner of Death 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 🔀 Natural Accident Suicia 5 \square Pending injury ithin 24 hours after death.

the Funeral Director: Aignorphic Aign Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one) 29b. Signature and title of cortified 29c. License number 29d. Date signed (Month, Day, Year) 1,0118

CP 5 State

Registrar

30. Name and address of person who completed cause of death (Iterh 23a) (Type, Print)

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 ам Nancy Sue Courtney 08 9:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice of St. Mary's Mary's Mechanicsville 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Director 206-26-6193 02/05/1934 76 Washington, Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40310 Golden Beach Road Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates White traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Washington Post Distributor News Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Edward Marks Sara Josephine McCartney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and a Department of Health a Important: If item 27 inition or other tr Gaithersburg, MD 20878 <u> John E. Courtney — Son</u> 16001 Howard Landing Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 108/13/2010 Brentwood, MD Signature of Funeral Service Licensee Inc. 22. Name and Address of Facility Ft. Lincoln Funeral Home, Montgomey Cheat Cow 3401 Rladenshurg Road Brenty
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Priysician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate sause. Little Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 s this certificate 2 No 2 1 Yes 25. Was case referred to edical Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 6 Other (Specific Residence 6 Other Residence 6 Other (Specific Residence 6 Other) 2 12 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) r of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After **V** Natural injurv 5 Pending 2 🗌 No hours after death uneral Director: A Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 only one) 29b. Signature and title of certifier 29c, License number

CR 5

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leatherwood

D21031

12070 old line Center suite # 302 Walder F mp 20402

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Aug. Frances Laura Claggett 12, 11:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Hyattsville Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 6, 192 9. Birthplace (State or Foreign **Funeral** 1 M 2 Tr Months Hours Country) Lynchburg, VA 86 Director 255-36-6676 Dec Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Hyattsville 1₺ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Queens Chapel Road, #347B 20782 USA death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 Married withIn 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: **Black** "natural", Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Environmental Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Assistant 8 Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Shavers Laura Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Waters - Friend 12801 Old Columbia Pk., #230, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 8/13/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. mo Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate
Interval Between
Onset and Death
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Years Sequentially list conditions, if any, leading to minimal cause. Enter Underlying Cause (Disease or linjury Due to fur as a consequence of: Exami Hypertension Years that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last the burial attending physician for use as the buria Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) 9 Unknown the 9 Unknown P.O. ed by t detach signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires should t Osteoperosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Possible metastatic cancer 24a. Was an has page 2 autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4X Nursing Home 5 A Residence 6 Other (Specify) Hospital: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 E only one 29b. Signature and titl of certifie 29c, License number 29d. Date signed (Month, Day, Year) D19609 8/12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Raman Tuli

31. Date filed (Month, Day, Year) AUG 1 7 2010 10810 Darnestown Road, #202, Gaithersburg, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 105 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arunde1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace State or Foreign
Marry 1 and **Funeral** 212-30-4827 1**X** M 2 □ F Months Hours D(200th, 2019 Year 931 78 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be matter at a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapo1is 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Louis Dr. 21401 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) 12th Head Waiter Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert R. Carpenter Sr Nancy Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian L. Carpenter(Wife) 101 Louis Dr. Annapolis, Md. 21401 20a. Method of Disposition 20b. Beston (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Park 8-12-10 Annapolis, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee M. Mame a Rock as Social Sons Mortuary, P.A. 821 West St. Annapolis, Md. Jany MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death ₽πysician/ disease or condition resulting in death) Marth Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate outce. Enter orderlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the dor use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Director; After this certificate 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital. Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending injury ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) DU064379 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bustach Rd Sule DU Amendo

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AUG 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Lena Milbertha Foster Drummond 12, August 2010 01:08 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma PARK Montgomery if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) **Jamacia** . Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕱 F Months Days 217-21-5538 88 Yrs. Director August 7,1922 Westmoreland, Usual Residence of Decedent 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Exacting must be pulled at Director 1 X Yes 2 □ No Maryland Prince Georges Hyattsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5608 Elberton Place 20781 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black. 9 Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 years Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agatha J. Grant Cecil Foster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Heath Important: If item 27 any injury or other tr once. Carlton Alexander Drummond(Son) 7203 Cipriano Springs Drive; Lanham, Maryland 20706 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. 28, 2010 Westmoreland, Drummond Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Jamacia, West Indies gnature of Juneral Se von Line wee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acuke **Physician** -evebrovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consecuence of) requires that the death certificate be execute Exami and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as 1 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □ No detached 9X Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons page certificate 1 ☐ Yes 1 ☐ Yes 2 1 No 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2√1No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00060100 08-12-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TALM INV Almos 31 University BVLD SagL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 7 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{Year}}{10}$ Loretta Florine Falcone 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Worcester Atlantic General Hospital Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗚 F Months Days Hours Min. Director Washington, DC 96 577-01-3109 Usual Residence of Decedent shov 10a. State 10b, County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 143 Jamestown Rd., Unit 1 21842 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛂 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify. Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 000 Own Home Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Antonino Pedone Gertrude Pedone Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107/1913 Dolores M. Craig / daughter Jamestown Rd., Unit 1, Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State Date 1 DeBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park! 8/20/2010 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 208:121 suya 108 William St., Berlin, MD 21811 rart 1. Into the disease, or complications the description and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) LOLON Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of). sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the burial Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death g Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an pege 2 s has autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ဥ 1 Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After tompleted filled in by the funeral 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6:10 P

10d. Inside City Limits

white

Approximate Interval Between Onset and Death

Day

1 X Yes 2 □ No

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 3 2010

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Marilyn Jean GREENSPAN Month Physician/ 7:25 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Hospice Rockville Montgomery 8. Date of Birth (Month, Day, 1arch 27 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🂢 F Months Hours Year) New York 67 Director 094-34-2517 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Clarksville 1 🗆 Yes 2 💆 No Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5199 Ten Oaks Road 21029 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 🗆 XNo Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Own Home/Cosmetology Homemaker/Businesswoman Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any liury or other traumatic event once. 17. Father's Name (First, Middle, Last) ပ Paul Abraham Kaplan Ralphian Kantor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7400 Nevis Road, Bethesda, MD 20817 Leah Hodor, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3X Removal from State 4 Donation 5 Other (Specify) 08/15/2010 Pinelawn, NY Wellwood Cemetery 21. Signature of June Service Line 100 Torchinsky Hebrew Funeral Home 20012 Carroll St., NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Breast Cancer Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicial dompleted filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: Hospice 2 🗓 No ၉ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 6 August 13, 2010 D 37142

Registrar

State

31. Date filed (North, Day, Year)

16

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman, M.D., 1355 Piccard Drive, Rockville, MD

32. Registrar's Signature

			Please Type or Print in Black I		
			_ POF	partment of Health and Men Prtificate of Death	tal Hygiene 2010 27173
	Physicia	ın/	Decedent's Name (First, Middle, Last) Herbert GEND	FR N	Oate of Death Month Day Year 11:25 AM.
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Igust. 13, 2010
war !			3330 N. Leisure World Blvd., #819	Silver Spring	Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday) 4. Yrs.	Months Days Hours Min. (/	oate of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country) Ph. 17 1918 New York
	how how	ŗ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Maryla 28a-f s	recto	Maryland Montgomery Silver	Spring	1 ☐ Yes 2 X No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant if item 27 is marked other than "matural", or items 23a or 28a-f show amortant in items or items 23a or 28a-f show amortant in items of items 23a or 28a-f show amortant in items of items of items of items of items or items of items	Funeral Director	3330 N. Leisure World Blvd., #819	10f. Zip Code 20906	10g. Citizen of What Country? United States
	death vitems		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Ricar	res or No- n, etc.) 14. Race - American Indian, Black, White, etc.
920	s after ral", or Exami	Completed by	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Married Forces?	1 ☐ Yes 2) ☐ No Specify:	Specify: white
2-0	2 hour "natu	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of working	16b. Kind of Business Industry
121	led within 7 I Hygiene. other than ent, the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired) te Printer	Bureau of Printing
Maryland 21215-0036	filed w al Hyg d othe	Be c	17. Father's Name (First, Middle, Last) Israel Gendler	18. Mother's Name (Firs	st, Middle, Maiden Sumame)
ryla	uld be d Ment marke natic	욘			Hershkowitz
Ma	d 2 should be file alth and Mental H 27 is marked of traumatic ever			ling Address (Street and Number or Rural Rou I Clear Creek Drive,	
Baltimore,	je 1 and 2 si t of Health a If item 27 i or other tra		I LA DUIN 2 LI CIEINALION 3 LI NEINOVALIONI STATE	ematory or other place)	20c. Location - City or Town, State
Iţim	permit. Page Department of Important: If any injury or once.			emorial Gardens 08/15 errohinskystlebnew Fund	
Ba	Depar Depar Impor any in			54 Carroll St., NW, W	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mo d e of dying, such as cardiac or res	piratory arrest, Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death) a. Multiple Myeloma Due to (or as a consequence of):		
	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events		
	ath certificate be executed attending physician and for use as the burial-transit	<u>9</u>			
190	icate k g phys s the l	ledic	d		
Box 68760	th certif ttending or use a	Physician/Medic		Ectopic pregnancy	23d. Date of del ivery Month Day Year
. Bo	he dea y the a iched fe	hysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	U Other (specify)	
, P.O.	or Attending Physician: The law requires that the death certificate by after death. Director: After this certificate has been signed by the attending physis in by the funeral director, page 2 should be detached for use as the t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
rds	v require s been si should	eted			24a Was an 24b. Were autopsy findings available
3ecc	he law te has vage 2 s	Completed by			autopsy performed? prior to completion of cause of death? 1 Yes 2 V No 1 Yes 2 V No
tal	s ician : The la certificate ha rector, page	Be C	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only	Λ
Ϋ́	Physic r this caral dire	2:	1 Inpatient 2 FR/Outpati		5 📝 Residence 6 🗆 Other (Specify) Describe how injury occurred
ou c	anding sath. rr. Afte	ficate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ocation (Street and Number or Rural Route Number, Oity or Town, State)
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve		
	the Fithin 24	Me	only one) Sertifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certain	, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
	12+1		\ T \ /	29c. License number D 35635	August 13, 2010
-	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Joseph Kaplan, M.D., 18111 Prince Pl	Print) nilip Drive, #327, 01	ney, MD 20832
	Sta Registr		31. Date filed (Month, Day, Year) AUG 16 2010 22. Registrar's Signature		
			MUG - V CUIU MENTANA POR PET		

P.O. Hospital or Attending Physician: The law requires Records, Division of Vital within 24 hours after death.

To the Funeral Director: A completed filled in by the fu To the within 2

Maryland 21215-0036

altimore,

Box 68760

State

Registrar

10

FAMILL, MD

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE.
SHAMIN SHAMIN HIS. WASHINGTON ADVENTIST HOSP., TAKOMA PARK, HD-20912 32. Registrar's Signature

29c. License number

D-592-84

29d. Date signed (Month, Day, Year)

8/12/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No [1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN WAYNE HALL 9:04 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Doctors Hospital Lanham Prince George's 6. Sex 1 🖾 M 2 □ F Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, **Director** 225-04-6432 60 Virginia Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Prince George's Lanham 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8919 Hickory Hill Avenue 20706 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) altimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Melvin Hall Mary Helen Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Dubose - sister 6613 Adrian St, New Carrolton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carmer Memorial 8/7/10 Fieldale, VA Signature of Funeral Service Lin Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Monar disease or condition resulting in death) n/chow. Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury for as a consequence of unknown Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi 10that initiated events resulting in death) Last Due to/(or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed I 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Tes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 D Yes 2 🗌 No Investigation 6 Could not be Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

AUG

16

Good huckld, Lank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOLI OW AS 309 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 4771 Sands Rd. Harwood 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** May 25 1 M 2 D F Months Days Hours 1916 Maryland 94 Yrs. **Director** 218-14-2178 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel 1 ☐ Yes 2 X No Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 4771 Sands Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or DatesW . W . Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2X No Specify: Specify: **Black** 3X Widowed 4 ☐ Divorced II 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Welder Bevard Brothers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Thomas James H. Holt Sr and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is Leslie Holt-Vega(Daughter) 4773 Sands Rd. Harwood, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Adams U.M. Church 8-16-10 Lothian, Md. injury 4 Donation 5 Other (Specify) Miname a Roacissof ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ ANCREATIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. if yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Pregnant at time of death
☐ Unknown Month Year Day been signed by the should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las | autonsy within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 TYes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of 29c. License number BALVE me and address of person who comple ed cause of death (Item 23a) (Type_Print) NDAM 444 1 2 2010 32. Registrar's Signature State Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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Funeral	5	N O FIE	f Under 1 Year fonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		Birthp Count	lace (State of try) h Caro	or Foreign
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or 28a-f sho e notified at Director			10f. Zip Code			10g. Citize	en of Wha	t Count		X
er must be Funeral		2609 Harrington Road	216			USZ	<u> </u>			
or item aminer n by Ful		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{\te}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\texit{\text{\texi}\text{\texit{\texi{\texit{\texi{\texi{\texi{\texi\texi{\texi{\texi}\texit{\texit{\texi}\texit{\texit{\texi{\te	s Decedent of H es, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - A Black, V			
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marke marke matic	ŀ	William T. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Malling A	Address (Street)	and Number or Run	Marie Wa			e. Zip C	ode)	
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or oth	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition Cearmeter Creek Church Cem	on (Name of ory or other place Rapt 1	St Augu	nst 16, 2010		ation - Cit			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	-	21 Signature of Funeral Service Livensee	lame and Addre	ss of Facility			opvi			
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit manifested in by the filled in by the filled in the f		29a. Certifier (Check conty one) 1 Certifying Physician: To the best of my knowledge, death occurrence (Check conty one) 2 Medical Examiner: On the basis of examination and/or investigation of the best of my knowledge, death occurrence (Check conty one) 2 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check conty one)	ation, in my opini	on, death occurred a	t the time, date ar	nd place, a	and due to	the cau	use(s) and ma	anner stated.
within To the comple		29b. Signature and title of contine	29 c. Licens	e number	- 2	29d. Date	signed (M			
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State Registrar		31. Date filed (Month, Day, Year) AUG 1 3 2010 32. Registrar's Signature	West	3747 entle 2000,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21, 2010 Year AUG. **Physician** SHIRLEY ANN JONES 7:15P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PORT TOBACCO 7795 PORT TOBACCO ROAD 8. Date of Birth 9. Birthplace (State or Foreign MD Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months Hours Min. 217-32-0491 1 □ M 2 🛛 F 74 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at MD. CHARLES PORT TOBACCO 1 ∐Yes 2 🕍 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20677 U.S.A. 7795 PORT TOBACCO ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE ð 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE LATHROUM LEONARD COLLINS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 GRAYTON LANE NANJEMOY, MD. 20662 SHERRIE KING-DAUGHTER Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MON disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ficate has been signal page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 0 No certificate this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After I 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; A
letely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier npletely (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ Annie Mae Jones 20 To 3:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 902 D Royal Street Annapolis Anne Arundel . Social Security Number 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 U M 2 X F Apr 28 1922 virginia Director 230-30-7717 88 Usual Residence of Decedent 28a-f show is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 902 D Royal Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) should be filed within and Mental Hygiene. Custodian Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Hugh Newbill Willie Newbill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Jones (Son) 902 D Royal Street Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Bird Lane Cemetery 8-14-10 Rocky Mount, Va. 4 ☐ Donation 5 ☐ Other (Specify) M Marne a Racass of Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Deal Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) modiale Medical Examiner 4 rs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (* 35 a consequence of) Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Year 5 Other (specify) Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MelliTus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate h performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 NO Hospital 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining Prijoscianin to the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Deten

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	ľ	for State Registrar	State of Marylan		irtment of F tificate of L		Mental Hy	giene Reg. No.2 (010	27180
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Medic Examin		Winston Edward Kin 4a. Facility Name (if not institution, give str	reet and number)		4b. City, Town, or	r Location of Dea	August	4c. Cou	inty of Death	1
Funeral		Bowie Health Care 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month D	th	9. Birtl	orge's hplace (State or Foreign
Director	_	579-32-9866 Usual Residence of Decedent 10a, State 10b. County	81	Yrs.	ation		Sep. 2	9, 1928	3 Vir	ginja
28a-f sh	Funeral Director	Maryland Prince G	_		·					10d. Inside City Limits 1 X Yes 2 □ No
s 23a or	neral 🗅	10e. Street and Number 12319 Stonehaven L	ane T25		10f. Zip Code 20715			10g. Citizen	of What Cou	untry?
permit. Page I and 2 stoud be the award and a stoud a street dearth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 X Married	2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give	lf 1	/as Decedent of H Yes, specify Cuba	ın, Mexican, Puer	specify Yes or No- to Rican, etc.)	E	Race - Amer Black, White	, etc.
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Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 🗌	Ectopic pregnanc Other (specify)	÷У			Date of deli	very Day Year
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ours after aral Direc		4 Homicide determined	building, etc. (Specify)				City or Tov	vn, State)		al Route Number,
the Fune	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse	ian: To the best of my knowle ryOn the basis of examination pactioner: To the best of my	and/or investig	gation, in my opinio eath occurred at the	n, death occurred e time, date and p	at the time, date a	and place, and	due to the ca	ause(s) and manner state
		29b. Signature and title of certifier	um		29c. License		१	29d. Date sign	ned (Month, - 9 -/ 3	* *
10+1			MUSON COURT		Bowie M	D 30.	116 Jeff	rey Ho	eck. N	1.D.
State Registra	e r	31. Date filed (MATUG), 121 2010	32 Registrar's Signatu	be	K					

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Dorsey Joseph Lovell 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 27 9. Birthplace (State or Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 🖫 M 2 🗆 F 91 213-18-8596 June Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☐ No Frederick Smithsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21783 13426 Stottlemyer Rd. U.S.A12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luella Irene Smith John Floyd Lovell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13440 Stottlemyer Rd. Smithsburg, Md. 21783 Larry K. Lovell (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Garfleid United Me Church Cemetery 1 Burial 2 ☐ Cremation 3 Removal from State Aug.24 Garfield, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final court Year

Physician /Medical Examiner

permit. Pages 1 and 3 Decartment of Health Important: If item 27 any Injury or other tr

27

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be

၉

Md.

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment mast be recitived at

72 hours after death with the Maryland

d be filed within 7 antal Hygiene.

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

/Medical

Examiner for use as the burial-trans Physician/Medical detached signed by t Be Completed by Atter this certificate has been s funeral director, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Certification: To filled in by the

resulting in death)	a .	aim 2	- con
resulting in deality	Due to (or as a consequence of):	1	
Sequentially list conditions, if any leading to immediate	b. Kenal dôrow Due to (or as a consequence of):		24000
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):		
	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of deliver Month D	y Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	. 1
		24a. Was an autopsy perfor to compete death? 1 □ Yes 2 □ No 1 □ Yes 2	sy findings available pletion of cause of
25. Was case referred to medical examiner?	26. Place of	Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursia	ng Home 5 ☐ Residence 6 ☐ Other (Specify))
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? on M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural City or Town, State)	Route Number,

Medical completely

29b. Signature and title of certifier

29a, Certifier

and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D 28365 8-23-10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** Month Earle જ 30P M Edna Lang 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 751 East Fourth Street Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 30, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 DF Director 213-24-6500 82 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Exercises many in the product of the content of th 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 751 East Fourth Street 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: 3 XWidowed 4 ☐ Divorced white Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eston I. Fultz Marie A. (Mongold) Fultz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonja Moon 751 East Fourth Street Cumberland MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Øremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/21/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pard. Enter the mode of dying, such as cardiac or respiratory arrespiratory arrespiratory arrespiratory arrespiratory contains the contained of dying, such as cardiac or respiratory arrespiratory arrespirato Approximate Interval Between Onset and Death Immediate Cause (Final lasla 0 **Physician** evernone disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 2 □No 1 ∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 □ Ro Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending investigation death. ours after death.

Neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 20/0 D0033280

State Registrar DHMH 17 Rev 1/2001

le

625 KENT AVENUE CUMPERLAND MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUPTA M.

31. Date filed (Month, Day, Year)

AUG 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 6:45A TUQUST 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** oex 1 X M 2 □ F Min. Days Yrs 49 162-54-2895 Director Sept. 12, 1960 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2X No must be notified PA York Stewartstown 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ 23a Funeral 14086 Ridge Road 17363 USA items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Transportation 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Anna E. Stremmel Robert L. Mancha ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any Injury or other trauone. Karen M. Mancha/Spouse 14086 Ridge Road, Stewartstown, PA 17363 20b. Place of Disposition (Name of Cemetery Crematory or other place)

Black Rock Church of the Brethren Cemetery Aug. 27, 2010 Glenville, PA

22. Name and Address of Facility J. J. Hartenstein Mortuary Inc 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the at Id be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performe Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 \(\subseteq \) No Hospital: 1 npatient Other: 4 \square Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 12 29 1981 27. Manner of Death 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🔲 Natural 1 Yes Head (011,50 n 16:30 death. 2 Accident 01 after death Director: / filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Street Highway Jorret15 Ville within 24 hours a

State Registrar

completely

Medical

AUG 30

31. Date filed (Month, Day,

29a. Certifier

29b. Signature

30. Name a

and manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print)

0

Year)

Lacritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Inez Dale Mitchel] 2010 9:58 <u>August</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5074 Summer Day Lane Columbia Howard . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Min Oct 14, 1937 Maryland **Director** 218-36-6726 72 Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5074 Summer Day Lane 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 K Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ <u>Social Worker</u> <u>Federal Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pullen John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph D. Mitchell/husband 5074 Summer Day Lane Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) inal Journey Crematory 8/14/2010 Woodbine, Maryland Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ reinoma Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin and-tran-Due to (or as a consequence of): resulting in death) Last physician a s the bunal Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed Yes 2 2 No ☐ Yes 1 Yes Division of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pendina Accident Suicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of (Item 23a) (Type, Print) and address of pe

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 954PM Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** or Mary If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numb 7. Age (In yrs. last birthday) **Funeral** No (Month 2Day, Yeg)70 Min. Hours 1 XM 2 □ F MaryTand 39 217-78-3064 Director Yrs. Usual Residence of Decedent show 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f Thurmont 1 X Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral U.S.A. items 23a 134 Water Street 21788 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Penelope Marie Beard David Emanuel Misner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Water Street, Thurmont, Maryland 21788 Rachel L. Misner / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Blue Ridge Cemetery 1 X Burial 2 Cremation 3 Removal from State 8/14/2010 Thurmont, Maryland 4 Donation 5 Other (Specify) ROBERT E. DATLEY & SON FUNERAL HOMES, EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autopsy perform ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ျှ 1 🗌 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: . Manner of Death 28b. Time of 28d. Describe how injury occurred eral Director; After filled in by the funer Natural iniury 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотретер 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) tree dia

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			amend #5 State of Maryland % 1 - State Registrar	Department of Health and Ce <i>rtificate of Death</i>	Mental Hygie	711111 / / 186
		В	1. Decedent's Name (First, Middle, Last)	11.	2. Date of Death Month	3. Time of Death
	Physici: /Medic		Juner Mall	Miles	August	15 2010 1430 PM
	Examin		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Dea	ith	4c. County of Death
	Funeral		5. Security 109748 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year I If Under 24 H.	s. 8. Date of Birth	9. Birthplace (State or Foreign
	Director	-	579-18-7046 1 □ M 21€ F 79	Yrs. Months Days Hours Mir	(Month, Day, Ye. 2/18/193	1 Country) Washington, DC
	pu 🚜		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	f short	ō				1 ☐ Yes 2 😿 No
	the N	Director	MD Worcester Ocean 10e. Street and Number	Pines 10f. Zip-Code	10a.	Citizen of What Country?
	death with the Maryland rms 23a or 28a-f show must be notified at		4 Wood Duck Dr.	21811		SA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	ould be filed within 72 hours after death with the Marylan Mental Hygiene. Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2★ No If Yes, Give	1 ☐ Yes 2x No Specify:	no modifi, etc./	Specify: white
Maryland 21215-0036	hours ural",		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a.	Decedent's Usual Occupation	16	b. Kind of Business/Industry
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212	d with giene. r thar the M	omi	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemaker		Own Home
פ	al Hyg	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, Ma.	iden Surname)
<u>X</u>		인	Frank Hall		Gainer	
Jar	s 1 and 2 should f Health and Mer item 27 is mark other traumatic			Mailing Address (Street and Number or		
4	s 1 and of Health item 27 other tr			Wood Duck Dr., Oce		MD ZISII c. Location - City or Town, State
وّ	permit. Pages 1 Department of I- Important: If ite any injury or ot		1 Burial 2 Cremation 3 Removal from State cemeter	y, crematory or other place)		
saltimore,	nit. P artme ortani injury		21. Signatur of Fureral Service Licensee		7/2010 F Surbage Fun	rankford, DE
ñ	land be be be be be be be be be be be be be		Witsia Builes	108 William St.	Berlin, M	D 21811
			23a. Part 1. Exter he disease, or complications that caused the death. Do n shock, or heart fallule. List only one cause on each line.	ot enter the mode of dying, such as card	ac or respiratory arrest	, Approximate Interval Between
F	hysician			mmatory Respons		Unset and Death
	/Medical Examiner		resulting in death)	ரி:	9 97.670	,,,,
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesus of Figure 1)	η):		
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2/00, 2/00,	death certificate be executed e attending physician and ed for use as the burial-transit	edical	d			
200	g phy as th	Med	IF FEMALE:			
X POX	th cer endin or use	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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> : 5 ;	nysici is cer I direc	5 B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 Residence	e 6 C Other (Specify)
֓֞֞֜֜֜֝֓֞֜֜֜֜֟֓֓֓֓֓֓֜֟֜֜֟֓֓֓֓֓֓֓֓֓֓֜֟֜֜֓֓֓֓֡֡֜֜֡֓֡֓֡֡֡֡֡֡֡֡	ng Pr		1 🔀 Natural 5 □ Pending (Month, Day Year) Ir	ime of 28c. Injury at Work?	28d. Describe how i	injury occurred
VISION	tendi death. tor: A the f	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, far	M 1 Yes 2 No	29f Location /Street	et and Number or Rural Route Number,
<u>}</u>	or At after of Direct	ertification:	4 Homicide determined building, etc. (Specify)	m, street, factory, office	City or Town, St	
	or the hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	O	29a. Certifier (check only 2 Medical Examiner: On the basis of examination and			
:	ne Ho lin 24 he Fu npletel	Medical	one) and manner stated.			
i	North Con	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		-	· Elizabeth King	RES-000	AL	igust 15 2010
DI	014		30. Name and address of person who completed cause of death (Item 23a) (Elizabeth King) North Wolfe	St, Baltimore, MD, 21287
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			,,,
	Registra	ar	AUG 17 2010 Beneva S.	19 acres		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registra MEND#20er IME, 8/25/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2010 Craig Delin Miller Äugust 7:47 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 6523 East Halbert Road Bethesda If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav 8. Date of Birth (Month, Day, Year) Funeral 1 € M 2 🗆 F 215-58-9458 57 Director Jan. 20,1953 Washington, D.C. I sual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 1 c
1 and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f snow.
7 is marked other than "natural", or items 23a or 28a-f snow.
7 is marked other than "natural", or items 23a or 28a-f snow. MD Montgomery Bethesda Director 1 √Yes 2 No 10e Street and Number 10f Zin Code 10g Citizen of What Country? 7620 Old Georgetown Road Apt. 724 20814 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other trainment Irvin T. Miller Doris L. Westberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris L. Westberg/Mother 7620 Old Georgetown Road, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetary, crematory or other place)
Geo, Wash. Uinversity
Medical Center 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. of Funeral Service Lic /M00969 9013 Annapolis Road, Lanham, MD 20706 2 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Immediate Cause (Final disease or condition resulting in death) **Physician** HEAD MYXIA MON 376 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No e Hospital or Attending Physician; 1 24 hours after death. e Funeral Director; After this certifica letely filled in by the funeral director, pa 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation Aug 6 2010 1 ☐ Yes 2 No 2 Accident unt 6 ☐ Could not be 3 Suicide lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number of City or Town, State) 6 5 2 2 5 a 5 T Ha 4 Homicide home Bethesda mD 20814 Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo oma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 Mank photo v + 4 BRECHER, MOOME 31. Date filed (Month, Day, . Registrar's Signature State parks Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARAIO 10:30 A M 12 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring Prince George's Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 € M 2 □ F NY Director 579-36-0441 Nov. 7, 1917 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Medical Eva nice must be retiffed at 1 □Yes 2¥□No Director MD Silver Spring 10f. Zip Code Prince George's 10g. Citizen of What Country? 10e. Street and Number USA 3148 Gracefield Road, Apt. 211 Funeral 20904 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1x Yes 2 No
If Yes, Give
Year or Dates: 1940–45 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Broadcasting Elementary/Secondary (0-12) College (1-4or 5+) Broadcast Engineer Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Maraio 2 Marian Monacelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard D. Maraio/Son 3156 Gracefield Road, #313, Silver Spring, MD 20904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 17 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature Funeral Service Lenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Examiner Se Dentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be exect Due to (or as a consequence of): Box 68760, physician Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No RETENTION 24a Was an has HYPERTHROPHY certificate PROSTATE 1 □Yes Division of Vital the Hospital or Attending Physiclan: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? NURSINGS Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) REHA 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29c, License number **D** 57284 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 힏 AUG 12 2010 man, MD 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEFIELO R-P SILVER SPRING MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. Na Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 5, 2010 Year Physician/ McCauley James Francis 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12329 Flamingo Lane Bowie Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🕅 M 2 🗆 F Hours 0272671924 New Jersey Director 147-18-6503 86 Usual Residence of Decedent show "natura", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Prince George's Maryland Bowie 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12329 Flamingo Lane 20715 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Yes Ses, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced Year or Dates. 1943-45 White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Litton Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman/Designer Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James McCauley Mae McKeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Eileen Williams / Daughter 12329 Flamingo Lane, Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans 8/13/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ congesti disease or condition Medical resulting in death) Examiner concagano Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. I signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: "within 24 hours after death."

No the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 **N**0 Other: မ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending iniurv 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) use and title of certifier 00060120 5-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 mirchellville Rd #B-216 Hagethma

Registrar
DHMH 17 Rev 7/2009

State

1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dec nts Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIIL Medical (if not institution, give street and number) **Examiner** Town, or Location of Death County of Death 42 DON Madólis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Day Year Min. M 2 □ F Months Hours Country Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1. Tes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes. Give Specify 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+))CCP1014 Be 17_ Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) Grand ac ughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16-2010 Riverdalek Signature of Funder DSDRINGENID 20146 710 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on et Immediate Cause (Final alana Frysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consequence of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Deal 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

AUG 1 7 2010

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State of Maryland / Department of Health and Mental Hygiene

		•	For State of Ma	aryland ———	-	tificate of D			_	<u>20</u>	10	27191
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Jaylon McAllistor					2. Date of Dea	ath 3	^{oay} 05	Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) 1409 Hollins ST			4b. City, Town, or		h	1	c. County	-	
	Funeral Director			e (In yrs. last	t <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	h v. Year)		9. Birthp	lace (State or Foreign
_		r	Usual Residence of Decedent 10a, State 10b, County	10c, City,	Town or Loc	ation		10/19/	200	<u> </u>		Od. Inside City Limits
	Marylar 28a-f s otified	irecto	Maryland N/A		1tim							1 ☐ Yes 2X No
	with the 23a or 1st be n	Funeral Director	10e. Street and Number 1409 Hollins St.			10f. Zip Code 2122:	3		10g. C	Citizen of V US	What Coun	try?
336	2 should be filed within 72 hours after death with the Maryland than do Marth Hygiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 Never S Company S			as Decedent of His Yes, specify Cubar ☐ Yes 2 📉 No		pecify Yes or No- o Rican, etc.)		14. Rac	e - America k, White, e	etc.
Maryland 21275-0036	72 hour n "natur Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give ki	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of wor	rking	16b.	Kind of Bu	usiness Ind	
1212	ed within Hygiene. other tha ent, the N	Be Cor	Elementary/Seconday (0-12) College (1-4 or 5-	+)		N/A				N/		
/land	should be file n and Mental H 7 is marked of raumatic ever	To B	17. Father's Name (First, Middle, Last) Jahlil McAllister					me (First, Middle, . u Young	Maider	n Sumame	e)	
	12 shoul lith and f 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Jahlil McAllister(Fathe		-	Address (Street al		ral Route Number Baltimo				,
Baltımore,	1 and of Hea item othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	2 P Plac	of Dispos	Name of allory or other place	e)	Date	20c.	Location -	City or Tov	wn, State
altim	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Mem		L Garder		13-10 s Morti				Md.
20	De a L De		Jarry A. Relsento 23a. Part 1. Enter the disease, or complications that caused	the death		21 West				Md.	2140	
	Tiysician/	6	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			and mode of dying	, scor as cardiae	or respiratory arr	001,			Approximate Interval Between Onset and Death
	Medical Examiner		Due to (or as a	consequen	nce of):							
	ed nsit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	consequen	ice of):							
	cate be executed physician and s the bunal-transii	al Exa	that initiated events resulting in death) Last C. Due to (or as a	consequen	nce of):							
0/8	tificate b ng physi as the b		IF FEMALE:									
. Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live Birth 2 1 Pregnant at 9 Unknown	2 🗌 Fetal d	leath 3 🗌	Ectopic pregnancy Other (specify)	'			23d. Dat Mor	e of deliver	ry Day Year
7. 5.	es that t signed by be deta	ρ	Part II. Other significant conditions contributing to death but	ıt not resulti	ing in the un	derlying cause give	en in Part I.					e cause of death?
Sords	iw requir as been s 2 should	Completed						24a. Was a	an	24b. V	Vere autop	sy findings available
ř	n: The la ificate ha or, page		25. Was case referred to medical			26 Pla	ce of Death (Chec	perfor 1 Yes	med?		leath?	
r VITA	hysicia this cert al direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatie			3 DOA Other	4 Nursing H	lome 5 KResid				
0 00	ending leath. or: After he funer	Certificate:	1 ★ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident ☐ Investigation	Year)	b. Time of injury	28c. Injury work? M 1 \(\sum \) Y	at ′es 2□No	28d. Describe ho	ow inju	ry occurre	ed	
DIVISION OF VITAL RECORDS,	to the hopogrial or Attending Physician: The law requires that the death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for a		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	. (Specify)				28f. Location (Si City or Town	n, State	=)		
:	the Hos nin 24 hc the Fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of machiner on the basis of exponential one of the basis of the	amination ar	nd/or investig	ation, in my opinion	, death occurred a	at the time, date ar	nd place	e, and due	to the caus	se(s) and manner stated
			29b. Signature and title of certifier Ashley Menchel M.D	•		29c. License	_	2	29d. Da		(Month, D	ay, Year)
(KA.	- 1	30. Name and address of person who completed cause of de	ath (Item 23		nt)				. , -		
	Stat Registra	е	ASHEN MUNCHEL, MD 600 31. Date filed (Month, Day, Year) 32. Begistrar AUG I 2 2010	North r's Signature	Wolte	St cmsc	600 Bu	hmore, M	ND.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year SHBEL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heart Homes Annapolis Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Sept. 16. **Funeral** 9. Birthplace (State or Foreign 219-54-3999 1 M 2 X F Months Days Hours Mir Year! 84 Director 1925 Scotland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b, County 10c. City, Town or Location by Funeral Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 979 Headwater Road 21403 Scotland 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. White ₩XWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Jewelry Store Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Campbell Janet McVicar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Seon Lange/daughter 979 Headwater Road Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burlal 2 Kircremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 8/13/2010 Baltimore, Maryland Truneral S 22. Name and Address of Facility John M. Taylor Funeral Home 01 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause out of line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition HY Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes SENO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🗗 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Hursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 10 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Suicide Investigation 1 🗌 Yes 2 🗌 No 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined building, etc. (Specify) Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

AUG 1 3 2010

139 Old Solomons Island Rd.

Annapolis, MD 21401

Moorheud, Richard

				Plea	se Type or Pr						_		_	.	
			For State Registrar		State of N	naryian		artment of I <i>tificate of I</i>			та пу	Glene Reg. N	0010	27	193
	Physicia	an/	1. Decedent's Nam	,							. Date of De	eath		- 1	of Death
7	Medic Examir	cal			orhead Sr.			4b. City, Town, o	r Location		70400		2 2010 c. County of De		364 M
	, LAGITIII				hington Mi			r 6len	Burn	110			Anne	Arun	
	Funeral Director		5. Social Security N 213-42-	3031	6. Sex 7. A	ge (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours		Date of Bir 1971/39		4 Ba	irthplace (State)	
	/land f show ed at	tor	Usual Residence o 10a. State	10b. County			y, Town or Lo	cation						1	City Limits
	or 28a-	Director	MD 10e. Street and Nu	Anne A	rundel	0de	nton	10f. Zip Code				10a C	Citizen of What (Yes 2 🕅 No
	s 23a onst be	Funeral	12	12 Oden	ton Road Un	it 21	4	21113				_	USA		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	11	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	?		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☐ No			y Yes or No- an, etc.)		14. Race - An Black, Wh Specify: W	ite, etc.	
15-0	72 hou "natu ledical	nplet	(Sp	15. Deceden ecify only highes	r's Education t grade completed)		(Give I	lent's Usual Occup	during mo	st of working		16b.	Kind of Busines	s Industry	
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Maryland	ıld be filed Mental Hy narked oth atic event	To Be		Franci	s Roark Sr.					her's Name <i>(F</i> othy Ma			n Surname)		
	1 and 2 shound Health and item 27 is mitem 27 is mitem 2000 other traum		19a. Informant's N		p (Type, Print) nead Spouse			ng Address (Street Norwood							
Baltimore,	Page 1 au nent of H ant: If ite ury or oth		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	☐ Cremation	3 □ Removal from State Combment	e C		sition (Name of natory or other place in 11	ce)	Dat 08/16/		ı	Location - City $ook1yn$,		
Balt	permit. Depart Import any inj		21. Signature of F					Name and Addre	ss of Faci Fune 1	llity ral Hon	ne P.A	. 8	51 Anna ambrill	polis de la composición della	R9884
	Physician/	8 9	23a. Part 1. Enter shock, or hea Immediate Cause disease or conditi	art failure. List or (Final	complications that cause aly one cause on each lin	ne.					espiratory ar	rrest,		Approxir Interval E Onset ar	Between nd Death
-	Medical Examiner		resulting in death)	1	a. Due to (or as	a consequ	ence of):	2 Dismyal	Pur					1 00	,,,,
	d ii	Examiner	Sequentially list co if any leading to in cause. Enter Under	rimediate erlying	b. Drin to (or as	e oceanou	innos off:							1/0	
	executed ian and irial-transit		Cause (Disease or that initiated even resulting in death)	ts	c. Due to (or as	a consequ	ence of):	LITES						7 134	7
200		edica			d										
. Box 68760	that the death certificate be- ned by the attending physicia detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknowr	months? ☐ No	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of d	Ideath 3	Ectopic pregnand Other (specify)	су				23d. Date of o	elivery Day	Year
s, P.O.	requires that the de been signed by the should be detached	by	Part II. Other signi	ficant condition	ns contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Par	t I.	23e. Did t	_	use contribute		
of Vital Records,	or Attending Physician: The law requires Director: After this certificate has been sign in by the funeral director, page 2 should be	Completed									24a. Was auto	psy		utopsy finding completion o	
E R	i cian: The certificate rector, pag	Be Co	25. Was case refer	red to medical	9		-	26. P	lace of De	eath (Check or		ormed?.	No 1 🗆 Y		
Vita	Physician: this certific al director,	은	examiner?				ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗆 N			dence	6 ☐ Other (Spe	ecify)	
o uo	nding F ath. : After 1 e funera	cate	27. Manner of Deat 1 Natural 2 Accident	n 5 ☐ Pending Investig		ury ay, Year)	28b. Time of injury	28c. Injur work M 1 —			d. Describe l	how inju	ry occurred		
Division	l or Atter after des Director I in by th	Certificate:	3 Suicide 4 Homicide	6 Could n determin	ot be 28e. Place of In	jury - At hor tc. (Specify)		eet, factory, office		281	f. Location (S City or Tov		nd Number or F e)	ural Route Nu	mber,
Δ	To the Hospital or Attending Phys within 24 bours after death. To the Funeral Director: After this completed filled in by the funeral directors are successful to the funeral directors.	Medical	(Check 2	2 U Medical Ex	Physician: To the best of aminer: On the basis of	examination	and/or invest	igation, in my opini	on, death o	occurred at the	e time, date a	and plac	e, and due to the	e cause(s) and	manner stated.
	To the within 70 the Comple	Σ	only one) 3 29b. Signature and		Nurse Practioner: To the	e best of my	knowledge, c	29c. Licens	e time, da e number	te and place, a	and due to th	e cause 29d. Da	(s) and manner a ate signed <i>(Mor</i>	s stated. th, Day, Year)	
			ha	when	700,			D	6079	76		AU	16-51 12	, 2010	
C	45		WILLIAM	HA	ho completed cause of	death (Item	23a) (Type, P	29c. Licens O rint) TAL DA	TUE,	GLEN	Bun	NIE	MO :	2/0	6/
	Sta Registra	te ar	31. Date filed (Mon	AUG 1	32. Registr	rar's Signati	A. A	have							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			- StateAmended item# Registrar	26&28a,WCHD,		erti‡ieate of l			Reg. No.	0	27194
	Physicia	in/	1. Decedent's Name (First, Middle, La	•	MITTE			2. Date of Dea Month AUG) Year O T O	3. Time of Death
3	Medic	al	BEATRICE 4a. Facility Name (if not institution, giv	E.	MILLE		r Location of Death		4c. County		8:40 P M
	Examin	er	ATLANTIC GENERAL			BERL				RCEST	ER
	Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs, last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthp	olace (State or Foreign
	Director		131-14-7231	1 □ M 2 X) F 9	91 Yrs	. Months Days	Hours Willi,	FEB. 2,	1919	NEW	YORK
	nd how at	,	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				1	0d. Inside City Limits
	anylar la-fs ified	ect	MARYLAND MONTGO	OMERY	BETHI	ESDA					1 ☐ Yes 2X No
	or 28	흅	10e. Street and Number			10f. Zip Code	****		10g. Citizen of V	Vhat Cour	itry?
	s 23a	Funeral Director	5101 RIVER ROAD,	APT. 1814		20816			USA	Δ	
	death item	Ē	11. Marital Status	12. Was Decedent Ever	in U.S. 1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		e - Americ	
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates.		1 🗆 Yes 2 🛣 No	Specify:		Specify:		ITE
2-0	hour 'natur	Completed	15. Decedent's (Specify only highest g		16a. De	cedent's Usual Occup	nation	king	16b. Kind of Bu	usiness Inc	dustry
2121	nin 72 ne. than * e Me	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	life	. DO NOT use retired)	_				
2	d with Hygien ther i	امها	17. Father's Name (First, Middle, Last)	4	1 1	EXECUTIVE_	18. Mother's Nan		GOVER		T
Maryland	be file ental l ked o c eve	10 E	·	, BAUM			MOLLI		GOLDSTE		
ary.	nould nd Me s mar		19a. Informant's Name/Relationship (19b. M	ailing Address (Street					Code)
Σ	id 2 sh alth a n 27 la er tra		JONATHAN MILLER/	'SON	4916	REDFORD	RD, BETHE	SDA, MD	20816		
ore	of He of He if item ir oth		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 [Removal from State		sposition (Name of rematory or other place	ce)	Date	20c. Location -	City or To	wn, State
Baltimore,	t. Page tment tant;		4 Donation 5 Other (Spec	cify)	CREMATO	RY OF DELM		2/10	DELMAR	, DEI	AWARE
Bal	permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nı any injury or other traumatic event, the Medio		21. Sign fire Figure 1 Service Licer	1 see		22. Name and Addre	•	IOME, SE	LBYVILLE	E, DE	. 19975
			23a. Part 1. Enter the disease, or cor shook, or heart failure. List only	nplications that caused the one cause on each line.	death. Do not	enter the mode of dyir	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Pnysician/ Medical	9.3	Immediate Cause (Final disease or condition resulting in death)	a. CARR	sopuln	IONARY	ARR	EST			Onset and Death
	Examiner		resulting in death)	Due to (or as a con		ZTIC S	T= 10) C	15			30 minutes
25		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor		2116	IEIVU	>1)		_	
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00:70	death certificate be executed the attending physician and ed for use as the burial-transit	sal E	resulting in death) Last	Due to (or as a cor	nsequence of):						
£ 29 8760	ificate t ig phys as the l	Medical		■ d							
£ 50 2	certifi anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		3 ☐ Ectopic pregnan	27		23d. Dat	te of delive	ery
157 727 Boy		Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at tim 9 Unknown	ne of death	5 Other (specify)			Мо	nth	Day Year
20°0.	The law requires that the rate has been signed by the page 2 should be detach	y Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying cause gi	ven in Part I.	23e. Did to	bacco use contr	ibute to th	ne cause of death?
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Po 8- po p. ecords,	law require has been si e 2 should I	Completed						24a. Was a	an 24b. V	Were auto	osy findings available mpletion of cause of
Rec	sician: The la certificate ha irector, page?	Som						perfo	rmed?	death?	
Ø G	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Chec	ck only one)			
7.cc	S 0 0	<u>1</u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient	2 X ER/Outpa	tient 3 DOA Oth	4 ☐ Nursing H	ome 5 Resid)
Beatric 251 Sion of Vit	Attending or death. ector: After by the funer	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Yea	ear) injur	y worl		28d. Describe n	ow injury occurre	ea	
Bee 12261 Ision	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could not	be 290 Place of Injuni	At home, farm,	street, factory, office			treet and Number	er or Rural	Route Number,
O.	ital or irs afte ral Dir led in	a C		building, etc. (Sp	респу)			City or Tow	n, State)		
M:116	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral	Medical	(Check 2 Medical Exam	ysician: To the best of my laner: On the basis of examinate Practioner: To the best	ination and/or in	vestigation, in my opini	on, death occurred a	at the time, date a	nd place, and due	e to the car	use(s) and manner stated.
$\Sigma \overline{\omega}$	To the within 2 To the сотрlе	2	29b. Signature and title of certifier	1 / 1 decioner. To the best	or my knowledg	29c. Licens			29d. Date signed		
	6		Debut	& / held	2	MD	D 58380		AUGUST	10,	2010
	SN		30. Name and address of person who		, , , , , ,	e, Print)			WENCENS	TO27	MD 20005
			Deborah S. 31. Date filed (Month, Day, Year)	BEZSKY , u.		# 10810 CC	NNECTICU	T AVE.,	KENSING	TUN,	ZU895
	Stat Registra		AUG 16 2		A. X	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Day 08^{nth} Physician/ 201Ŏ 0540 М James Morse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly, MD Prince George;s Prince George's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number Funeral 1 🌠 M 2 🗆 F Hours Washington, 80 577-38-3987 Director 05/24/1930 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director D.C. Washington 1X☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5916 Southern Avenue, SE 20019 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Truck Driver 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Morse Elizabeth Endless 19a. Informant's Name/Relationship (Type, Print)
Evelyn Morse - wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5916 Southern Avenue, SE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery 20c. Location - City or Town, State 9 1 X Burial 2 Cremation 3 Removal from State Mt. Washington, DC 08/16/2010 injury o 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 719 Kennedy St, NW Tyrone J. Young Funeral Svcs. Washington, DC 20011 23a. Part 1 Enter the disease, o shock or heart failure. List Immediate Cause (Final ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Que to for as a nonsequence of it any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performe 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical æ Hospital Other: 1 ☐ Yes 2 ☐ No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier backs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wash & 200

DHMH 17 Rev 7/2009

Registrar

AUG 16 2010

32. Registrar's Signature

Amend 23e, per MD G910 12/20/10 TT State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Violet Zoellner Noppert 1:45 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Hours 80 Director 285-26-8936 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Anne Arundel Severna Park MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 447 Rivendell Lane 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Zoellner Viola Betz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Noppert / Husband 447 Rivendell Lane Severna Park, MD 21146 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State August 12 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f g Unknown 9 Unknown P.O. signed by a persist of the size of the siz Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown Records, certificate has been si rector, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? the Hospital or Attending Physician; The law performed? 2 No Yes **Division of Vital** Be 25. Was case referred to meetical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Speci 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 21401 sate Rd Ste 300 State AUG 1 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mooth 230 O'Brien Clarence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-RMC Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Jan 24 1 🗆 M 2 🗆 F Months **Director** 214-07-4850 91 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director **Pinto** MD Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14216 Walter Drive SW 21556 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 □KWidowed 4 □ Divorced Specify Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Corp laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert O'Brien Ella Mae (Valentine) O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Roger O'Brien P.O. Box 142 Cumberland MD 21502 son item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite injury or 1 X Burial 2 Cremation 3 Removal from State Fort Ashby Cemetery 8/21/2010 WV 4 Donation 5 Other (Specify) Fort Ashby 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Euneral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pary 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ a. Respiratory to disease or condition Medical resulting in death) Examiner 9 days Dudo (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine 9 days attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 1 Yes 2 No ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fracture ribs 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Chest trauma. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy or Attending Physician: The 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 2 Accident 5 Pending work? Acto ACCIDEN 24 hours after death. Funeral Director: A Investigation 10 Place of Injury - At home, farm, street, factory, office utilding etc. (Specify) 6 Could not 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ermin 5713 ME mules Hury ChrsAptown HISTOWA Hospital Medical Certifying Pysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) MANI WILLOWBROOK RD. STE. 670 CUMBERLAND, MD 21502 ARR 31. Date filed (Month AUG 30 State 2010 Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 11:45 A M August Barbara S. Purvear Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Jefferson 4436 Gene Kemp Road 8. Date of Birth (Month, Day, Nov. 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Hours 1 □ M 2 🛣 F _{Virginia} Director 69 Nov. 26-52-1966 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21755 4436 Gene Hemp Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married δ 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Executive Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Isadora Shumate Oscar Dolinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4436 Gene Hemp Road Jefferson, Maryland 21755 Carter Puryear / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) 16, 2010 Frederick, Maryland Resthaven Mem Gardens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. . Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ al Medical resulting in death) Due to (or consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Date to for as a consectuence off. signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MABPTEG autopsy 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 🗓 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred After 1 Natural injury 5 Pending iours after death.

neral Director: A
filled in by the fu 2 Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 (Check only one) e and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

Frederica MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Hemen

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4:45 PM Physician/ Beatrice C. Powell 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Hyattsville Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min (Month, Day, Year) 1 🗆 M 2 😾 F 81 578-34-8801 Director 05/06/1929 77.4 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Capitol Heights MD P.G. 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20743 705 Opus Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after 1 Yes 2 No Specify: Specify: White Hygiene. other than "natural", 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Home Maker should be filed with and Mental Hygien 7 is marked other th Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Annie Mae Horner Andrew Griffith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15205 Graaf Place., Silver Spring, MD 20905 f Health Phillip Powell / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of b Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/17/2010 Brentwood, Maryland Fort Lincoln Cem. 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee JUN 3401 Bladensburg Rd.Brentwood, MD 20722 23a. Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENCEPHALOPATHY mmediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner INTO CARDIAL /SCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit SEP515 Cause (Disease or iinjury that initiated events Que to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical NEUMONIA IF FEMALE: detached for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown DILBETES 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No DISEASE ARTERY 24a. Was an autopsy performed? Yes 2 XNo this certificate has al director, page 2 To the Hospital or Attending Physician: The 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Funer completed file certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

29h. Signature and

31. Date filed (Month, Day, Year)

AUG 1 7 2010

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(M nn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

HOSPITAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

As Facility Name (front Institution, pive street and number) As Facility Name (front Institution, pive street and number) As Facility Name (front Institution, pive street and number) As Facility Name (front Institution, pive street and number) As Facility Name (front Institution, pive street and number) As Facility Name (front Institution, pive street and number) As Facility Name (front Institution) As Facility Name (front Inst			te gistrar	e (First, Middl	e. Last)	4			Ce	ertifica	te of L	Death		2. Date of [Reg.	No. 20	110	2.	720
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betwee Onset and Death Interval Betwee	tor	579-	14-49	31	6. Sex	M 2 □ F								3. Date of E 04/02	Birth 19/1/92	20			te or Foreig
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lips and the disease of injury that initiated events resulting in death) Lips and the disease or condition as a consequence of): Due to (or as a consequence of): Du	neral D	362	9 Pat								2103					Unit	ed S	tates	
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24a. Was an autopsy findings avail prior to completion of cause performed? 24b. Were autopsy findings avail prior to completion of cause death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred 28d. Describe how injury occur	ρ Δ	Part II. (Other signif	cant conditi	ons cont	ributing to	death bu	t not resu 11	ulting in the	underlying	cause giv	en in Part I.							
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28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office	icate: To Be	exar 1	niner? Yes 2 ner of Death Natural Accident	No 5 Pendii	ng gation	28a. Dat	e of injury	/	28b. Time	of	Othe 28c. Injury work	er: 4 Nursin	g Home	5 🗆 Re				VORI	PILE
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Praction of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gentier 29c. License number 29c. License number 29d. After signed (Month, Day, Year)	al Certii	4 🗆	Homicide	detern	nined	buil	ding, etc.	(Specify)						City or To	òwn, Sta	ite)			ımber,
Thrul 1 201	Medic	(C on	neck 2 ly one) 3	☐ Medical !☐ Certifying	Examine Nurse	r: On the b	asis of exa	amination	and/or inve	stigation, in death occu	my opinio urred at the	n, death occur e time, date and	red at th	e time, date	and pla the caus	ce, and due e(s) and ma	e to the c anner as	cause(s) and stated.	manner stat
30 Name and address of person who completed/cruse of death (Item 23a) (Type, Print)		30 Nam	e and addre	ss of person	w o con	npleted/c	use of de	ath (Item	23a) (Type,	Print)	D :	M430	5	1	Z	rgu	wt I	112	010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For Amend Item State Registrar	3 per dr.,g	907',097 C	21/2010dhb ertificate of <i>E</i>	Death	IVICITICAL I 198	Reg. No.20	10	27201
Pi	hysicia		Decedent's Name (First, Middle, La. Joseph	st) Travers		Ruppe	ert	2. Date of Dea Month August	Dav	Year 2010	3. Time of Death 2:45p
~ E	Medic xamin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County		12.20
			Julia Manor Heal			Hagerst				ningt	
	ineral rector		265-50-0351	© M 2 □ F 7. Age (In)	yrs. last birthday Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec 24	Year) 1935	9. Birthi Coun Ma 1	place (State or Foreign cyland
rland	f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location				1	0d. Inside City Limits
Mary	28a-1 otifie	irec	MD Washing	gton	Hagers						1 X Yes 2 ☐ No
ith the	3a or t be r	ral	10e. Street and Number			10f. Zip Code			10g. Citizen of \		ntry?
eath w	ems s	Funeral Director	333 Mill St. 11. Marital Status	12. Was Decedent Ever i	n U.S. 10	21740 3. Was Decedent of His If Yes, specify Cubar		pecify Yes or No-		S.A.	an Indian,
after de	", or it	ρ	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give		If Yes, specify Cubar 1 ☐ Yes 2 🎇 No		o Rican, etc.)		ck, White,	
13-0050in 72 hours after e.	atural cal Ex	Completed	3 Widowed 4 Divorced	Year or Dates.	16a Dec	cedent's Usual Occupa				Wn	
6 10 2 h	Medi	dmc	(Specify only highest gr Elementary/Seconday (0-12)		(Giv	re kind of work done d DO NOT use retired)		king	16b. Kind of B	usiness in	dustry
d with	t, the	o l			Di	sc Jockey			Rad		
YIGHO Id be filed Mental Hy	ked of	70 B	17. Father's Name (First, Middle, Last) Joseph Alphonsus	Ruppert				ne (First, Middle, I La Boyd J		9)	
nd Me	s mar umati		19a. Informant's Name/Relationship (7		19b. Ma	illing Address (Street a				State, Zip (Code)
, Mal od 2 sho ealth and	n 27 i		Travers B. Rupper	t/Son	197	58 Longmea	idow Rd.,	, Hagerst	town, M	21	742
Dalumore, Maryland Z IZ 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	t: If iter / or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	cemetery, cr	position (Name of rematory or other place	· .	Date	20c. Location -	,	
emit. Pa	portan y injun ice.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licenses)			ven Cemeter 22. Name and Addres		5/2010 est Have	Hagers n Funera		
	트등의		220 Part 1 Enter the disease or com	The street caused the		.601 Pennsy				n, MD	
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ficate be executed	physician and the burial-transit	cal E	resulting in death) Last	Due to (or as a con	isequence or):						
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requires	speen sid	sted		atio				1 🗆 Y			pably 4 Unknown
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an: i	tor, pa	ø	25. Was case referred to medical			26. Pla	ce of Death (Chec	1 \(\sum \) Yes	2 No. 1	I ☐ Yes	2
ysici		요 일	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	2 🗀 ER/Outpat	Other	r	ome 5 🗆 Reside	ence 6 🗌 Othe	er (Specify))
nding Pt	9 P E		27, Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time injury	work?		28d. Describe ho	ow injury occurre	ed	
To the Hospital or Attending Physician: The law requires that the death certificate that the death certificate the control of	in by the	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			street, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
Hospital 4 hours	red filled	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Exami	sician: To the best of my ki iner: On the basis of examin	nowledge, death	h occured at the time,	date and place, a	nd due to the cause at the time, date an	se(s) and manne	er as state	d. use(s) and manner stated.
o the l	omple		only one) 3 A Certifying Nurs	se Practioner: To the best of	of my knowledge	e, death occurred at the	time, date and pla	ice, and due to the	cause(s) and ma	inner as sta	ated.
F 3 F	- 0			oden-Bluche	~ CRNG		25 360		3/23/2		
2 4	1		30. Name and address of person who	completed cause of death ((Item 23a) (Type	, Print)	2	1	1.		
17	\		Barbara A. Na	den - Bluck	20 - 2	33 M:11 C	TOFFT	+ arpac	TOWN.	MD	21740

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] 27202 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Guillermo Roviralta 1630 August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery <u>Rockville</u> If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5ex 1 **X** M 2 □ F Sept 23, 1922 Costa Rica 87 217-92-3235 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11504 Paramus Drive 20878 Costa Rica 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1 X Yes 2 ☐ No Specify: Spanish Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry International Elementary/Seconday (0-12) College (1-4 or 5+) <u>Civil Engineer</u> Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josefa Redondo Ignacio Roviralta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11504 Paramus Drive Gaithersburg, Maryland 20878 Ligia R. Moss/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

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Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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attending physician a for use as the burialwithin 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	1 ☐ Burial 2 🔀 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		crematory or o	crematory 8	/17/	/2010 W	oodbine,	Maryland
	21. Signature of Funeral Service License		100957	Going Beverl	Home Cremat y L. Heckro	ion tte,	Service P.A. C	P.O. Bo larksvil	x 784 le, MD 21029
	23a. Part 1 Enter the disease, or comples shock, or heart failure. List only one disease or condition resulting in death)	cause on each line.	e death. Do not	enter the mod	e of dying, such as cardia	ac or res	spiratory arrest,		Approximate Interval Between Onset and Death Z DAYS
Examiner	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 3c. If yes, outcome of p 1 ☐ Live Birth 2	Fetal death	3 🔲 Ectopic				23d. Date of de	elivery Day Year
d by Firyard	1 Yes 2 No 9 Unknown Part II. Other significant conditions cor	4 Pregnant at tin 9 Unknown		5 Other (sp				o use contribute t	o the cause of death?
and lines						_	24a. Was an autopsy performed 1 Yes 2	prior to	utopsy findings available completion of cause of
3	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:			26. Place of Death (Ch		· · · · · · · · · · · · · · · · · · ·		
2	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	2 ER/Outpa 28b. Tim inju	e of 2	DA 4	\neg	5 ☐ Residence Describe how inj	6 Other (Speurry occurred	oify)
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		street, factory	, office		Location (Street a City or Town, Sta		ıral Route Number,
Medical Certificate.	(Check 2 Medical Examine	er: On the basis of exam	ination and/or in	vestigation, in	the time, date and place, my opinion, death occurred at the time, date and p	ed at the	time, date and pla-	ce, and due to the	cause(s) and manner stated

D 38262

29d. Date signed (Month, Day, Year)

2401 RESEARCH BLVD STE 330 ROCKVILLE MD

AUGUST 13, 2010

State

Registrar

29b. Signature and title of certifier

ANURITA

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRATTA

32. Registrar's Signature

MD

MENDH

parkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ August 8 10:57 A Maurice Robertson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Florida Months Davs Hours Min. (Month, Day, Year) 74 242-44-7706 Director Nov. Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f New Carrollton Maryland Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Z1215-0036

ZUILL Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "- any njury or other traumett- once. Funeral items 23a United States 20784 6516 Lamont Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married African 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Jazz Self-Employed Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 # 202 1745 T Street SE Washington, DC Monique Robertson- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date August 14, 2010 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. Washington, DC 20019 4001 Benning Road NE 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ENDOCARDITIS To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23h Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 🗌 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RAL CERP ONFARCT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes ည Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 7600 Carroll Avenue Tokoma Park, Maryland Piotr M. Wyrwinsk State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08\\dagger1\dagger4/2010\dagger3 1:30 P Rowland Michael Stevens Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 15 Dockside Ct. Berlin Worcester 8. Date of Birth (Month, Day, Year) 03/16/1938 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) Days Hours Min. 1 🙀 M 2 🗆 F 365-36-5931 72 Director MI Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√☐ No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 15 Dockside Ct. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 1 Married X Yes 2 ☐ No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MBA Physist Johns Hopkins Hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Casimir Francis Stevens Helen Mary Steinbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Stevens Dockside Ct. Berlin, MD 21811 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Sepulchre Cem. Sunfield, MI 21. Signature of Funer II Service Licensee 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD 21811 108 William St. 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTANC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner Other: 4 \(\text{Nursing Home} \) 15 \(\text{Sesidence} \) 6 \(\text{Other} \) Other (Specify) ျှ 1 Tes 2 500 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier

State Registrar

EMUIN

31. Date filed (Month.

10324 ON OCEMP CITY BUD SERVEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUTIMMENA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 15°, 20°°0 Physician/ Amanda Jean Simmons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Pocomoke City Worcester Hartley Hall Nursing Home If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min. 1 □ M 2 😿 F 01/28/1945 West_Virginia Yrs. Director 65 214-44-8652 Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County ıld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Pocomoke City MD Worcester 10e. Street and Number 10g. Citizen of What Country? 21851 USA 1006 Market Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify.White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Healthcare Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Brooks Edward Louk permit, Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bloomfield 1728 Cedar Street, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date old Brick Church Cem. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Huttonsville, W 8/21/2010 21. Signature of Funcial Service Licensee 22. Name and Address of Facility 107 Vine Street Holloway Funeral Home, P.A., Pocomoke City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Division of Vital or Attending Physician; 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျင 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it 5 Pending work 2 Accident
3 Suicide Investigation
6 Could not be 1 🗌 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MI 00062172 8/16/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD POLOMOKE CITY 21851. BA2 R SATYAL, MD MI) 1604 MARKET ST 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

8:05 PM

1 Yes 2 No

Year

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 50 Eva Mae Soloway August 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCESS ANNE MANOKIN MANOR SOMERSE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/15/1927 Birthplace (State or Foreign Country) Social Security Number Months Days Hours 1 □ M 2 🛛 F 213-22-8740 82 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No VA Mappsville Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14141 Lankford Hwy. 23407 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Elite Cleaner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Burke Mary Agnes Danegan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Patricia Lynn Godfrey / daughter 14141 Lankford Hwy, Mappsville, VA 23407 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State Bates Cemetery 8/21/2010 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUT Sycars disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner 95AM law requires that the death certificate be executed physiclan and s the burial-trans P.O. Box 68760, Division of Vital Records, or Attending Physician: funeral director, After this

certificate has been signed by the rector, page 2 sh uld be detached

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, IT-21 once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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within 24 hours after deatl To the Funeral Director: filled in by the

Completed by Be

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician/Medical Exam Certification: To

1712 State

completely

Hospital

29b. Signature and title of certifier mherah

investigation

determined

6 ☐ Could not be

The Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the dadacts, and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number Do51359

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN: DR-USHA

1415-5. DIVISION ST, SALISBURY (Mignet 14, 2010

31. Date filed (Month, Day, Year) **AUG 17** 32. Régistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1-	For State Registrar		State of Ma	aryland	d / Depa Cer	irtment of F tificate of L	Health Death	and Me	ental Hy	giene Reg. No		272	207
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	mine	1 4a. F	acility Name (if not institution 1620 N. Park					4b. City, Town, o					c. County of Dea		
Fune Direct		46	58-40-0714	6. Sex 1 🗌	M 2 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. F	B. Date of Bir	th y, Year)	934 g. Bir	thplace (State o	r Foreign ada
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baltimore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en			Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from State	cei	metery, crem	ition (Name of atory or other place M orial G	· .	Dat ns 08/			ocation - City or		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			MALE: Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	230	c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	≥ 🔲 Fetal :	death 3 📙	Ectopic pregnand Other (specify)	;y				23d. Date of de Month		ear
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the Hospi hin 24 hou the Funer npleted fil	Medical		only one) 3 Certifyin	Examiner g Nurse)F	an: To the best of no control of the basis of expractioner: To the basis of the bas	amination a	and/or investi	gation, in my opinio	n, death oc	ccurred at the	e time, date a	nd place	, and due to the o	ause(s) and man	iner stated.
12		29b.	Signature and title of certific	1	Af			29c. License	number 33293			29d. Dat	te signed (Month August		0
		F	lame and address of person rederick P.						., #1	300, (Chevy	Chas	se, MD	20815	
S Regis	state strar	31. D	ate filed (Month, Day, Year) AUG 16 2	010	82. Registrar	's Signatur	SAR	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month John Thomas Schlebecker August 11, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1 **X** M 2 □ F Months Days Hours Feb. 8, Day 1923 317-16-0315 87 Director Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring 늅 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral 103 Belton Road 20901 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ★ Yes 2 □ No If Yes, Give Year or Dates. 19 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White r than "natural", the Medical Exa 3 ₩Widowed 4 Divorced Completed 1942-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Museum 5+ Curator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental F tant: If item 27 is marked o မ Erwin Schlebecker Emma Wiseman Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Belton Road, Silver Spring, MD 20901 David J. Schlebecker/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Cramatory Date 13, Aug. 13 2010 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Arrest Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami requires that the death certificate be exequted that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death the 9 Unknown g 🗌 Unknown P.0. signed by t I be detach ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Stroke Records, Completed 24a. Was an or Attending Physician; The law has page 2 autopsy performed Yes 2 XNo **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2X No Other: မ 1 Inpatient 2 XER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 1X Natural 5 Pending thin 24 hours after death.

the Funeral Director: After the function by the function of the fu 1 🗌 Yes 2 🗌 No 2 Accident Investigation

20c. Location - City or Town, State Alexandria, VA Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) August 13, 2010 1500 Forest Glen Road, Silver Spring, MD 20910

6:30

9. Birthplace (State or Foreign

10d. Inside City Limits 1 🗌 Yes 2 🌁 No

Indiana

a M

State

Medical

Hospital

To the within 2 To the

Suicide

4 Homicide

only one)

29a. Certifier

29b. Signatur

6 Could not be

tale of certifier

Ghousia Sultana, MD

determined

s of person who comp

Registrar DHMH 17 Rev 7/2009 29c. License number

D56691

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

eted cause of death (tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gary Allen Shores, Jr.	
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	State of Maryland /	Department of He	ealth and Me	ental Hygien

	Gary Allen Shor	es,	Jr. 1- For State Registrar	Sta	te of Maryla		ertificate of		and	Mental Hy		Reg. N	. 20		2720
	Physici Medical Exami		1. Decedent's Nan		ORES Gai	y Alle	n Shores	Jr.			2. Date of De Month	eath Day	/ Year	Ť	3. Time of Death 0741 hrs
4			4a. Facility Name	(if not institution,				4b. City, Towr	n, or Lo	cation of Death	August 2		4c. County of	Death	
	Funoral		1204 Cox No. 5. Social Security		. Sex	7. Age (In yrs.	last hirthday)	Chester	Year I	If Under 24Hrs.	Is Date of F	Rirth/MI	Queen Ar		nplace (State or
	Funeral Director		217-96-3		X M 2 F	46	• • • • • • • • • • • • • • • • • • • •	Months	Days	Hours Min.	JUNE			Foreign	RIPLAND
00	any		Usual Residence of	of Decedent 10b. County	-		y, Town or Locati	00				. , .			10d. Inside City Limits
80	*	_	MARYLAND	QUEEN	ANNE'S	100.01	CHES'								1 Yes 2 No
12	ith the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Nu					10f. Zip Coo	le		- <u> </u>	10g. C	itizen of Wha	Coun	try?
	th the l 23a or notifie	Ë	1204 COX	NECK R					619				NITED S	TAT	TES
	eath wi	Funeral	11. Marital Status 1	ed 2 Marr	ied Armed Fo	edent Ever in lorces?	J.S. 13. Wa	s Decedent of es, specify Cu	f Hispar ıban, M	nic Origin? (Spe exican, Puerto F	ecify Yes or N Rican, etc.)	10-	14. Race White,		an Indian, Black,
	after d	by Fi	3 Widowed		1 Yes ced If Yes, Give Yea or Dates:	r	1	Yes 2 X	No s	pecify:			Specify:	WH]	TE
	2 hours "natu	sted	15. Decedent's E Elementary/Sec		only highest grad					(Give kind of wo NOT use retire		16b.	Kind of Busin	ness/In	dustry
	5-0036 led within 7 Hygiene. I other than	Completed	9				SUB CO	ONTRACT	ГOR			В	OME IM	PRO	VEMENT
	215-0 be filed v ntal Hygi rked oths ent, the l	Be Co	17. Father's Name GARY ALL		·					Mother's Name (· ·		
	212 nould be d Ment is mark tic ever	To B	19a. Informant's Na				19b. Mailing	Address (S		OROTHY nd Number or Ru				State,	Zip Code)
	, MD and 2 sho ealth and em 27 is		DOROTHY 20a, Method of Dis		/ MOTHER	1 20h	1204 (COAD, CHE	Date		RYLAND Location - C		
	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2	Cremation			f temaks h		33111311		ST 27,	,	RAPPE,		
	altin emit. P epartme iportar jury or	1	4 Donation 5 21. Signature of Fu						ress of l	Facility	s Meta				
			23a. Part I. Enter the	ne disease or co	Helfere	used the deat	108	SHAMI	KOCK	ROAD,	CHEST	ER,	MARYLA	ND T	IOME, P.A. 21619
7	Physician /Medical		failure. List or Immediate Cause	ly one cause on	e do line. a. Narcot								iook, of flear		Between Onset and Death
	Examiner		or condition resulti	ng in death)	Due to (or as a			ana ar	COII	or inco	ATCACI	.011			
		iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	Due to (or as a	consequence	of):								
	nted d ansit	edical Examiner	(Disease or injury t events resulting in	hat initiated death) Last	Due to (or as a	consequence (of):								
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	3760 ificate b ig physical s the bu		IF FEMALE: 23b. Was decedent		-	outcome of preg	gnancy			Ectopic pregnan			3d. Date of de	livery Da	y Year
	Box 6876 e death certificat the attending phy ed for use as the	Physician/M	past 12 months	s? √o9 Unkno	4 Pregna	ant at time of d	noth -	er (Specify)		etopic pregnan	Cy	7	MOUTH	Da	y real
	D.O. Box 6876 that the death certificate need by the attending phydeached for use as the	Phy	Part II. Other signi		9 ОПКПО		esulting in the ur	nderlying caus	se giver	n in Part I.	23e. Did t	tobacco	use contribu	te to th	e cause of death?
	Records, P.O. Box 68760. The law requires that the death cortificate cate has been signed by the attending physpage 2 should be detached for use as the b	d by									1 Ye	s 2	No 3	Proba	bly 4 🗸 Unknown
	Division of Vital Records, rat or attending Physician: The law require its after death. "I Director: After this certificate has been silted in by the funeral director, page 2 should be	Completed									24a. Was	psy	prio	r to cor	psy findings available apletion of cause of
	Rec : The l iffcate h	5	05 100		T						1 Yes	ormed?	dea No 1 ✓	Yes	2 No
	Vital ysician his cert directo	B	25. Was case reference examiner? 1 ✓ Yes	2 No	Hospital:	patient 2	ER/Outpatient			Death (Check on Pr4 Nursing		Reside	ence 6 🗸	Other: S	Scene
	1 of ' fing Ph	Ë	27. Manner of Deat	h		of Injury Day,Year)	28b. Time of Inj	· 1	njury at	Work? 2			jury occurred		
	ision Attender Per death rector:	icati	2 Accident	5 Pending Investige	ation UNK	of Injury - At h	unk ome, farm, street				unk	Street :	and Number o	r Rura	I Route Number, City
	Div pital or ours afte eral Dii	Certification:	3 Suicide 4 Homicide	6 X Could no determin	ot be			,,,			unk		and reambor o	· reare	Trode Hamber, Oky
	Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Medical (ician: To the best er:On the basis o	f examination a									
4	5 ½ § §	Me	29b. Signature and	title of certifier	and manner sta	ated.		29c. Lice	ense nu	mber		29d.	Date signed	(Month	ı, Day, Year)
	ans !		llueJ	2 4				0.0	C.M.E			Αυς	gust 23, 20	10	
	W.		30. Name and addre Ana Rubio N		o completed cause ant Medical E	•	111 Penn St	reet, Baltir	nore,	MD 21201					
	St: Regist		31. Date filed (Mont	h, Day, Year) AUG 25	2010 32. Re	gistrar's Signatu	ire h. ha	the s							
	regist	-11		FIVE DU	KUIU MP	4 mm	1- 1								

DOME

Shayla Shante Sikyala Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05889 2010 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0309 hrs Shante Sikvala August 6, 2010 Shavla Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's **New Carrollton** 6841 Third Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign akoma Park 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 215-79-3908 Director June 28,2007 Country Maryland 3 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 No s 23a or 28a-f show e notified at once. Prince Georges New Carrollton Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20784 Third Street 6841 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items | Examiner must be Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes **Black** Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Education Day Care Student Day Care 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Brooks** Dawn Yvette Kialuba Sikyala Nyunzi Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ 2 6841 Third Street; New Carrollton, Maryland 20784 Nyunzi Kialuba Sikyala (Father) If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, Aug.13,2010 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery Donation 5 Other Specify 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Licensee Inc.;600 Kennedy Street,N.W.;Washington,D.C.2001 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Wedical Death a. Gunshot Wounds (2) of Head and Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED physician the burial -UNPENDED Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth 2 Fetal death e attending for use as t past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 V No 9 Unknown the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed Records, page 2 should 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy performed?

Yes 2 No death? 2 No 1 V Yes certificate re Hospital or Attending Physician: T n 24 hours after death. re Funeral Director: After this certifica sletely filled in by the funeral director, pi 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 2 No 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot Certification 1 Natural FOLIND 1 Yes 2 🗸 No 5 Pending Aug 6, 2010 0306 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) 6841 Third Street, New Carrollton, MD determined (Specify) Residence 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 6, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month State AUG 1 Registrar

10-05890 Unk Unk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		<u>Itegistidi</u>	epartment o Certificate o		d Mental I		20 Reg. No.	10 2721	
Physician/ Viedical Examiner		Decedent's Name (First, Middle,Last)	Sikyala			2. Date of De Month	eath Day Year	3. Time of Death 0309 hrs	
		4a. Facility Name (if not institution, give street and number) 6841 Third Street		4b. City, Town, or I		August 6	4c. County of I	Death	
Funeral			rs. last birthday)	If Under 1 Year		Irs. 8. Date of E		9. Birthplace (State or oreign Cheverly,	
Director		212-71-3082 1XM 2_F 5	Yrs	Months Days	Hours M	in. Augus	2004 F st 12,	Country) Maryland	
any		Usual Residence of Decedent 10a. State 10b. County 10c. (City, Town or Locat	tion				10d. Inside City Limits	
*	ō	Maryland Prince Georges	New Car	rollton				1 X Yes 2 No	
Maryl r 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?	
with the Maryland ns 23a or 28a-f sho be notified at once.		6841 Third Street 11. Marital Status 12. Was Decedent Ever in			20784 Decedent of Hispanic Origin? (Specify Yes or No			tates	
death w	Funeral	1 Married 2 Married 2 Armed Forces? 1 Yes 2 N	lf Y	as Decedent of Hisp es, specify Cuban,	panic Origin / (a , Mexican, Puert	Specity Yes or Note (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	No- 14. Race - A White, e	American Indian, Black, etc.	
s after or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year	1	1 Yes 2 X No specify:				Black	
2 hours		15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)		nt's Usual Occupation ost of working life. I			16b. Kind of Busin	ess/Industry	
036 athin 7 ane.	Completed	lst grade	E1eme	ntary Sch	nool Stu	ıdent	Educat	ion	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)			18.Mother's Nam	ne (First, Middle,	, Maiden Surname)		
212 ould be Menta marke	lo Be	Nyunzi Kialuba Sikyala 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	Dawn and Number or	Yvette Rural Route Nu	Brooks umber, City or Town, S	State 7in Code)	
MD dd 2 sho		Nyunzi Kialuba Sikyala (Fathe	r) 6841	Third Sta	reet;Ne				
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	Ob. Place of Disposi crematory or oth	ition (Name of cemon ner place)	netery, Au	Date g.13,20	20c. Location - Cit	y or Town, State	
Baltimore, sermit. Pages 1 ar Department of Hee Important: If ite injury or other tr	1		Gate of H	leaven Cer	metery		Silver S	Spring,Maryla	
Ba perm Depa Impo		Canouish By	Inc	ame and Address o	of Facility R.	N. Hort	on Company	y Morticians,	
Physician /Medical	\Box	23a. Part I. Enter the disease, or complications that caused the deafailure. List only one cause on each line.	ath. Do not enter th	ne mode of dying, s	such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a. Multiple Gunshot Wo						Death	
		Due to (or as a consequence Sequentially list conditions,	e of):						
	iner	sequentially list conditions, if any, leading to immediate							
d	Examiner	(Disease or injury that initiatied events resulting in death) Last Due to (or as a consequence of):							
executed in and il - trans		d							
60, ate be ex hysician e burial	Medical	IF FEMALE: 23c. If yes, outcome of pr	regnancy				201 Date of deli		
687 ertifica ding p		past 12 months?	2 Feta	al death 3	Ectopic pregna	ancy	23d. Date of deli Month	Day Year	
Box e death of the attented for use	ysic	Yes 2 No 9 Unknown 9 Unknown	death 5 Oth	ner (Specify)			1		
P.O. I as that the gned by the detacher	by Phy	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	_		e to the cause of death?	
ords, P.C. w requires that us been signed to should be deta								Probably 4 Unknown	
of Vital Records, ng Physician: The law require Wher this certificate has been si	Completed					24a. Was autop perfoi		e autopsy findings available to completion of cause of	
DZ [.2 2.]	e Co	25. Was case referred to medical		26 Place of	of Death (Check	1 Yes			
of Vital ing Physician: After this certif	ď,	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient				Residence 6 🗸 Ot	ther: Scene	
J of Jing Pt After funera	Certification: To	27. Manner of Death 28a. Date of Injury	28b. Time of Inj		at Work?		how injury occurred		
Division tall or Attendiins after death.	catic	Pending Aug 6, 2010 O306 hrs 1 Yes 2 No Subject was shot 1 Yes 2 No Subject was shot 2 Polymer Aug 6, 2010 O306 hrs							
Division Spital or At a spital or At a spital or At a spital or At a spital birect filled in by	ertif	3 Suicide 6 Could not be determined Could not be determined (Specify) Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence 28f. Location (Street and Number or Rural or Town, State) 6841 Third Street, New Carrollton, MD							
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the Hos within 24 h To the Fur completely	ᇛᆫ	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	and/or investigation			it the time, date a			
	٦	Ma wante Routh - 11 mm		29c. License n			29d. Date signed (/ August 6, 2010		
A 1	30. Name and address of person who completed cause of death (Item 23a)							,	
L'		Pamela E. Southall, MD Assistant Medical Ex	caminer 111	Penn Street, E	Baltimore, M	/ID 21201			
Sta Registr	ite 3	31. Date field (Morth, 2010er) 2010 32. Register's Sign	me						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 11, 2010 11:15A Richard Edward Severe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1506 Delmont Lane Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 27, 1930 Washington, DC 1 ☑ M 2 ☐ F Hours **Director** 579-36-0722 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Prince George's Takoma Park ¹XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 USA 1506 Delmont Lane or items 72 hours after death "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No Maryland 21215-0036 White 1 Yes 2 No Specify. Year or Dates, KOREAN 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Manager Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Inez Mae Elizabeth Brock Howard Richardson Severe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Delmont Lane, Takoma Park, MD 20912 Naomi Ruth Severe - Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 8/17/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAN Royer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Acute Myocardial Infarction Physician/ Medical resulting in death) Due to (or as a consequence of): Examine Atherosclerotic Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician المنابع ملئة pas the المنابع be detached for المامة Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 4 ☐ Pregnant a
9 ☐ Unknown Year Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2X No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 \(\sum \text{Yes} \quad 2 \) \(\sum \text{No} \) Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DQA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III, Juan B. Arguinzoni, 6900 Georgia Avenue, NW, Washington, DC 20307-5036

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
AUG 1 7 2010

32. Registra's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Geraldine F. Scallan 2010 Aua 10 2:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12500 Kingsfield Lane Bowie 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 11 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖵 F Months Days Hours Min 1928 Connecticut 82 040-22-8486 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12500 Kingsfield Lane 20715 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Hygiene. other than "natural", 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Operator Telephone and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jeremiah Francis Kane Anne Sophia Brady 1 and 2 should to Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myles J. Scallan / Husband 12500 Kingsfield Ln., Bowie, MD 20715 or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 08/11/2010 Baltimore, Maryland 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, Maryland 20715 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition reast Physician/ Canco Medical resulting in death) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or ds a consequence of) and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician I for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 honths? Month Day Year signed by the a d be detached f Yes 2 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn 2 🗀 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this eral Director: After thi filled in by the funeral 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No after death Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cernine

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Baltimore, Maryland 21215-0036

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Box (

P.O.

Records.

Division of Vital

Registrar
DHMH 17 Rev 7/2009

State

Rd. #300 Annapoli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 2 2010

31. Date filed (Month, Day, Year)

900

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SMITH M8 38 0 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Whonth, Day ULY 27 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 ^{'ear} 1927 218-26-7934 Maryland Director 83 Yrs Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funera 135 Eastern Ave 21403 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc "natural", or þ 1X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12th 6yrs Educator Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles E. Smith Charlotte Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Lewis(Daughter) 3504 Cohasset Ave Annapolis, Md. 21403 20a. Method of Disposition 28) Place Appropried of Man@eddar 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Bluff. Cemetery 8-16-10 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licenses M Mame a Research Facilitisons Mortuary, 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed?

Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**No ၉ 1 Yes Other: 1 Ponpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date siggled (Month) Day, Year) 7 30. Mame and address of person who con

State

Registrar

AUG"1"2"2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20 1°0 Leslie Y. Smith 2:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5 Cypress Rd. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢F JUIN Day Year 949 Marwland 214-52-8059 61 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Cypress Rd. 21403 IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 K No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2XXMarried Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced B1ack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) 1yr Day Care Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John E. Thornton Ollie M. Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Smith Jr(Husband) 5 Cypress Rd. Annapolis, Md. 21403 20a. Method of Disposition 20b. Pile cspis main Mame of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 8-13-10 Annapolis, Md. 4 Donation 5 Other (Specify) Minima Resident Acid Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Reese 110048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on. To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day 5 Other (specify) Pregnant at time of death Year been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed Month, Day, Year, 3306

State Registrar 31. Date filed (Month. Day

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 3 2010

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Physicia		Registrar						2. Date of De	Reg. No. 2010 2 2 2. Date of Death 3. Time of Death		
Medical Exami								Month August 2	Day Year 1, 2010	2200 hrs	
		4a. Facility Name (if not institute 342 Bloom Street #5	. •	umber)	4	b. City, Town, o	or Location of Dea	th	4c. County o	f Death	
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Funeral Director		5. Social Security Numberuni		7. Age (III y/3.1	1	Months Da			· ·	Foreign Country) Mary Land	
		Usual Residence of Decedent 71 Yrs. Months Days Hours Min. Dec 4, 1938							Godniny/11d2 y 2d11d		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits			
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Bal permi Depar Impo injur	- [21. Signalur Funeral S rvice	S Wave	Director		Liam C	Brown Fu	neral H	omy Boar ome P.A. Baltimo imore, Ma	re. MD. 21201	
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/Medical		failure List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Between Onset and Death Death									
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Division of Vital Records, P.O. tat or Attending Physician: The law requires that the ras after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ğ							1 Ye	es 2 🗸 No 3	Probably 4 Unknown	
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tal Recol	ပ္တို	25. Was case referred to medica	ii l			26.Plac	e of Death (Check		2 10 1	163 2 110	
Vital I hysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	Hospital: Invariant 2 FR/Outnationt 3 DOA Other A Nursing Home 5 Residence 6 Other Scene								
ion of tending Pheath.	齚	27. Manner of Death	28a. Date (Month	of Injury n, Day,Year)	28b. Time of In	jury 28c. Inju	ury at Work?	28d. Describe	how injury occurre	d	
ion ttendi leath.	lgi	Accident Investigation 1 Yes 2 No									
Divisi pital or Att ours after de teral Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Dospital hours y fille		4 Homicide (Specify) 29a. Certifier , Consist of Deviction To the house of death appropriate the line data and place and due to the appropriate State of the second due to the second due to the appropriate State of the second due to the second d									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
T TE TO S	Med	29b. Signature and title of certifie	// and manner s	stated.		29c. Licens				d (Month, Day, Year)	
1		/ //				O.C.	M.E.		August 22, 2	2010	
	-	30. Name and address of person who completed cause of death (Item 23a)									
OCME	- 1	Mary G. Ripple MD.	Deputy Chief I	Medical Exan	niner 111		t, Baltimore, I	MD 21201			
St Regist	ate	31. Date filed (Month, Day Year) AUG 3 0 201	32. Re	egistrar's Signatu	rebook	,					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Addis Α. Taye 2010 8:45 p M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Mon tgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 X F Months Days Hours Min June 29 Director Ethiopia 211-64-2295 50 1960 Usual Residence of Decedent 28a-f shov 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD P.G. Hyattsville 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2008 Brighton Road 20782 USA items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Black 3 Divorced Specify Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Biologist** N.I.H Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဨ Taye Birru Ababa Girmave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> t. Page 1 and 2 sh tment of Health a tant: If item 27 i: Daniel Hailemariam/Husband 2008 Brighton Road, Hyattsville, MD 20782 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State oakwood Cemetery Aug 0104, 4 Donation 5 Other (Specify) Falls Church, VA 21. Signuale o Funeral Service Licensee 22. Name and Address of Facility Francis J. Coll 500 University E Tins Funeral Home Inc. Blvd. W., Silver Spring, MD 20901 wehard L Mates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Leukopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
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To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2**x** No **Division of Vital** 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 🎦 No ည 1 🗌 Yes Other: TXX Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending ☐ Accident 1 Yes 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certified 2 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

16

Add

ano

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Saved Elsayvad, MD 10110 Molecular Drive, Rockville, MD 20850

82. Registrar's Signature

D62435

August 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 80 ARGARET 2015 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, May 3 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 D Days Hours Min. 1959 Georgia **Director** 051-54-5690 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Anne Arundel Crofton 1 X Yes 2 □ No 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21114 1678 F Carlyle Drive U. S. A. items within 72 hours after death 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc ori δ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Office Manager Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 0'Neil Paul Augustine Teehan Anna Therese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Anne Teehan/Sister 7620 Old Georgetown #408, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Atlantic Crematory 8/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, Signature of Funeral Service Licensee bus 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivers 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Į Month detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? performed Yes 2 certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ... Certificate: To ER/Outpatient 3 . 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lucille Vannatta 3:23 Р. м 2010 Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5,1934 Birthplace (State or Foreign Country) **Funeral** 1 M 2 S F Months Days Hours Min. 170-28-3534 Director 76 June Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15004 Westbury Road 20853 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Schneider Trma Zurick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Vannatta, Jr./Husband 15004 Westbury Road, Rockville, MD 20853 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetary crematory or other place) Wash. University lical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service I /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ e disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 4 ☐ Pregnant at time of death g ☐ Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ည 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Fxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) AUSUST. 14, 2010 person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Drive Vladimir M. Rakhmanin, M.D. Olney, MD 20832

State

Registrar

31. Date filed (Month.

Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:44 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDE CHEN BURNIE MINGTON MEDICAL CENTER 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Director 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Completed by Funeral 8191 ORC 21122 15.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No f Yes, Give 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced hITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. PO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STANISLAWA ZEBRO LODANSK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INTHIA ZWORDT 53 MOUNTAIN RD. スリスス 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 Burial 2 Cremation 3 Removal from State MP 8-18-10 ODENTON 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa 22. Name and Address of Facility Day an ERTY STAIN RD. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year 1 Yes 2 the P.O. by signed b Part II. Other significant conditions buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 Probably 4 Unknown 1 Yes cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 🗌 No 1 Yes within 24 hours after death,

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 pital:
1 Impatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c ဂ္ Certificate: 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Principles of the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 of person who completed cause of death (Item 23a) Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010^{ea} 12:10 Rosemary Elaine Wheelock August AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care and Rehabilitation Center Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Dec. 1, 1931 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours Min Washington. 78 Director 577-40-3565 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State North 10b. County 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Brunswick Sunset Beach Camlina ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 493 Sandpiper Bay Drive SW 28468 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White "natural" 3 X Widowed 4 ☐ Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any lijury or other traumatic once. Charles E. Wood Grace Inglebressen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Wheelock 493 Sandpiper Bay Drive SW, Sunset Beach, North Carolina 28468 20a. Method of Disposition 20b. Place of Disposition (Name of August 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 16, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 2010 Cheltenham, Maryland ^{22. Name and Address of Facility}
Keeney and Basford PA Funeral Home,
106 E. Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease shock, or heart failure Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Physician/ ILE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial compileted filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2. 1 KI 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title

State Registrar

DHMH 17 Rev 7/2009

TOLL HOUSE HY. FREDERICK, MD

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

			For State Registrar	State of M	aryland		artment of F tificate of D			giene Reg. No.	010	27222
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	uneral			-	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.		h	Freder 3	place (State or Foreign
-		Į.	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		eation		may J,	1921		
Marylar	28a-fs	irecto		erick	- roo. Oity, it		Frederio	ek				10d. Inside City Limits 1 X Yes 2 □ No
with the	23a or ust be n	Funeral Director	10e. Street and Number 1713 W. 7th St.				10f. Zip Code	702		_	n of What Cou	•
land 21215-0036 be filed within 72 hours after death with the Maryland	of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E		l f	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	. Race - Americ Black, White,	can Indian, etc.
72 hour	in "natu Vedical	Completed	15. Deceden (Specify only highes	t's Education et grade completed)	1271	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)	ation uring most of wor	rking		of Business In	
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ylanc Id be file Mental t	arked o	To E	17. Father's Name (First, Middle, La Sheridan	•					ne (First, Middle, e e Potts	Maiden Sur	name)	
y, Mar nd 2 shoul	m 27 is m ner traum		19a. Informant's Name/Relationshi Ronnie West /	p (Type, Print) Son	1	9b. Mailin 814	g Address (Street a Waterford	nd Number or Ru	ral Route Number Frederi	; City or Tou	wn, State, Zip 0 D 21702	Code)
Baltımore, Maryland 21215-0036 pemit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mernal Horiere.	Important: If item 27 is marked of any injury or other traumatic even		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ☐ Removal from State	ceme	tery, crem	sition (Name of atory or other place 1 Cemeter	y 8/14		Woods		laryland
Depar	any in		21. Signatur Funeral Service Lie	Stan	the		Name and Address				neral F k, MD 2	
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J. DOX	by the attend ached for us	hysicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	Petal death	5 🗆	Ectopic pregnancy Other (specify)			23d	l. Date of delive Month	ery Day Year
us, r.O.	en signed build be det		Part II. Other significant condition CORONARY DIARETES				derlying cause give	n in Part I.				e cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	cate has bee	Completed by		MEL	LiT	US			24a. Was a autops perfor 1 Yes	SV	4b. Were autop prior to cor death? 1 ☐ Yes	osy findings available inpletion of cause of
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the Hospit in 24 hour	the Funera	Medical	(Check 2 \(\subseteq Medical Exa	Physician: To the best of naminer: On the basis of exalurse Practioner: To the b	amination and	or investig	ation, in my opinion	death occurred a	t the time date an	d place and	due to the cau	reals) and mannor stated
P P	5 000		29b. Signature and title of certifier The state of the s	loin, 1	MD		29c. License r	808	2	9d. Date sig	gned (Month, E	2010
2			80. Name and address of person wh			(Type, Pri	Frede	erick. r	m D 21-	70l		
R	State egistra		11. Date filed (Month, Day, Year) AUG 1	32. Registrar	's Signature	1.	Frede	- 10-10-1				
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P.O. Box 68760 Battimore. Maryland 21215-0036

			Plea	ase Type or Pri					•		egible.		
			For State Registrar	State of IVI	aryland	•	artment of I <i>tificate of I</i>	Health and N Death	Mental Hy	giene Reg. No. 2		272	23
	Physicia		1. Decedent's Name (First, Middle Leomar	, Last) Wright					2. Date of De Month	eath Day	A O I C	3. Time of Do	
	Medic Examin		4a. Facility Name (if not institution	, give street and number)	ire S,	I-le m	4b. City Town, o	r Location of Death	Hugu		unty of Deat		F
~	Funeral		V A Many land 5. Social Security Number 216-44-8642	6. Sex 7. Age	e (In <i>yrs. la</i> s:	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 04/11		g. Bird	hplace (State or F	oreign
	Director		Usual Residence of Decedent						04/11,	/194/	Mar	yland	
	Marylan 28a-f sh otified a	Director		rset	,	Town or Loc						10d. Inside City	
	with the 23a or 2 st be no		10e. Street and Number 30033 Kristwoo	d Way			10f. Zip Code 218.	53		10g. Citizen USA		untry?	
036	e filed within 72 hours after death with the Maryland Hylygiene. and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	If You Cive	No	lf	/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ame Black, White cify: bla	e, etc.	
15-0	72 hour In "natu Aedical	Completed	(Specify only highe	nt's Education st grade completed)	=-)	(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of work	ing	16b. Kind o	of Business	Industry	- 7
1212	d within hygiene. ther the nt, the N	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	U.S.	,					rnment	
ylanc	ould be filed id Mental Hy marked oth matic event	70 B	17. Father's Name (First, Middle, L Leon Wright	ast)				18. Mother's Nam Margaret				1	
, Mar	2 sh h an 7 is trau		19a. Informant's Name/Relationsh Marie J. Wrigh	ip (Type, Print) t spouse		19b. Mailin 300.	33 Kristv	and Number or Rura WOOD Way,	Route Number Prince	er, City or Tow SS Ann	n, State, Zic e , M D	21853	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 A Burial 2 Cremation 4 Donation 5 Other (S		cen	metery, crem	sition (Name of atory or other place n Cemete:	ce)	Date /2010		on - City or ehave		
Ball	permit Depart Import any inj once,	801											
ı	2). Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line.												en
, J	Physician/ Medical Examiner		limediate Cause (Final disease or condition resulting in death)	a. Due to lor as a								Onset and Dea	
	_xammer	ner	Sequentially list conditions, if any, leading to immediate	b. HY DERTO	a consequer	E ARi nce of): し	PISEASE	Erotic e	ARDIO V	nscul	2~	uears	-
	executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	c	a consequer	nce of):					- 4		
200	cate be ex physician the burial	edical		d									
Division of Vital Records, P.O. Box 68760	to the hospital or Attending Physician; The law requires that the death certificate be within 24 burst after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at g Unknown	2 Fetal d	death 3	Ectopic pregnanc Other (specify)	су		23d.	Date of deli Month	very Day Yea	r
P.O	r requires that the de been signed by the should be detached	þ	Part II. Other significant conditio	ns contributing to death be	ut not result	ting in the un	derlying cause giv	ven in Part I.				the cause of deat	
ords	w require s been s should	Completed		MONEY D	I'S ETA	< G			24a. Was	an 24	b. Were aut	obably 4 💢 Unlopsy findings avai	ilable
Rec	sician: The law certificate has l irector, page 2 s				13 913	,			autor perfo 1 Yes	rmed?	death?	ompletion of caus	se of
Vita	rnysiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆 EF	R/Outpatient	Othe	ace of Death (Checker: 4 Nursing Ho		dence 6 \square 0	Other (Speci	fy)	
on of	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Natural 5 Pending 28d. Describe how injury occurred work? 1 Natural 5 Pending 1 Natural 5 Pending 1 Natural 5 Pending 28d. Date of injury 1 Natural 5 Pending 1 Natural 5 Pending												
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	n 24 hours n 24 hours le Funera	Medical	(Check 2 \(\sumeq\) Medical E:	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	xamination a	ınd/or investig	gation, in my opinic	on, death occurred at	the time, date a	and place, and	due to the c	ause(s) and manne	er stated.
12	vithii To th		29b. Signature and title of certifier	(10	,		29c. License	number		29d. Date sig			^
	XEA		30. Name and address of person v	/ho completed cause of de		O 3a) (Type, Pr		628	1)	Muc	just	11,201	0
	Stat	e	Custodio, C	aro ina C) M (A Mary	land Hea	14h Car	eSyste	m, Per	y toint mo	2190
	Registra		AUG 16	2010 /	م ب	. April	Market						

			1 - For State Registrar	State of Mary			ent of Healt ate of Dea			Reg. No	010 6	27224
	Physici /Medic		Decedent's Name (First, Middle, La: Charl	,					2. Date of De Month August		y 201Ŏ ^{ear}	3. Time of Death 0510 M
	Examin		4a. Facility Name (If not institution, given Prince George's		enter		y, Town, or Locati Cheve	erly		40	County of Death	
4	Funeral Director		5//-44-9836	DOTAL OF E	yrs. last birthday) 96 Yrs.	Month		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da March	av, Year,	9. Birthp Cour 1914	lace (State or Foreign htry) DC
	show	'n	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation		Wach:	ington		1	0d. Inside City Limits 1 1 Yes 2 □ No
	with the N s or 28a-f be notified	Directo	DC 10e. Street and Number	NE		10f.	Zip Code	0019	Ington		tizen ot What Cour	ntry?
336	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be matified at once.	by Funeral Director	1561 45th Street 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	NE 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No tt Yes, Give Year or Dates:			cedent of Hispanic pecify Cuban, Mex 2 No Spec	Origin? (Sp kican, Puerto	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Aft	ean Indian, etc. ican
Maryland 21215-0036	ithin 72 hou nen *natura Nedical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	kind of t DO NOT	sual Occupation work done during i use retired)	most of work	cing .	16b. K	(ind of Business/Ind	,
12 pu	e filed w al Hygier I other th vent, thi	Be Cor	9th 17. Father's Name (First, Middle, Last)				Laborer 18. M	lother's Nam	e (First, Middle	, Maider	Priva Sumame)	ice
Z	should bad Ments	Tof	Edwa	ard Wilson	19b. Mailir	na Addre	ss (Street and Nu		Elizabe		ueen or Town, State, Zip	Code)
, Ma	end 2 sealth an m 27 is		Debbie Wilson/ Da	aughter	1110	7 Br	andywine	Road	Clint	on,	Maryland	20735
Baltimore,	Pages 1 nent of H ant: If ital		20a. Method of Disposition 1	Removal from State	ob. Place of Dispo cemetery, crer Harmon Park	natory o ny M	ame of rotherplace) emorial etery	Augu 2010	ust 18,		ocation - City or Ton	
Balt	permit. Departi Import eny inj		21. Signature of Funeral Service Licent	Stewart.	22	2. Name	and Address of Fa				al Home, ton, DC	Inc. 20019
l	Physician		23a Part 1. Enter the disease, or comp shock, or heart tailure. List only tmmediate Cause (Final disease or condition	one cause on each line.	death. Do not ent			n as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	insequence of):							
	ait sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co								
o	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	. ,							
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O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome ot p 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic Other	pregnancy (specify)				23d. Date of delive Month	ery Day Year
2	uires that signed b Id be deta	۵	Part II. Other significant conditions of Status Post Cardi			nderlying	cause given in Pa	art I.		tobacco Yes 2	use contribute to th	ne cause of death?
Vital Records,	The faw requir cate has been si page 2 should	Completed							24a. Was		24b. Were auto prior to co- death?	psy findings available impletion of cause of
<u> </u>	ician: Tr certificate rector, pa	Be Co	25. Was case reterred to medical examiner?				26. P	lace of Deat	1 ☐ Yes h (Check only	2 🔀 No		2[X No
> 	Physic this ce al dire	၉	1 ☐ Yes 2 🖾 No 27. Manner of Death		2 ER/Outpatien			Nursing Ho			6 □Other (Specif	y)
	Attending Physician: r death. ector: After this certific by the funeral director.	atlon	1 Accident 5 Pending investigation		ar) 28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2	2 □No	28d. Describe	now inju	ry occurred	
DIVISION	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, tarm, str pecify)	eet, fact	ory, office		28t. Location (City or To		nd Number or Rura e)	l Route Number,
	e Hosp 124 hours Fune tetely fit	edical	29a. Certifier (Check only one) 1 ★ Certifying Ph 2 ★ Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurre vestigati	ed at the time, date on, in my opinion,	e and place, death occur	and due to the red at the time,	cause(s date an) and manner as sid place, and due to	tated. the cause(s)
	Withir To the comp	Ž	29b. Signature and title of certifier	00000	1	2	9c. License numb	per		29d. Da	ate signed (Month,	Day, Year)
	,		30. Name and address of person who	completed cause of death			41/5	11	(08	111/10)
			Ophnell Alfred C	_	3001 Hos		1 Drive	Chev	erly, M	d.	20785	
П	Sta Registra	e	AUG 1 6 2010	General B.	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Leonard Appel, Sr. 8:30 P M August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harford 338 Regal Drive Abingdon If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Months Days Hours Min. Oct. 4, Year) 925 Director 213-20-3807 84 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Abingdon 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 338 Regal Drive 21009 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1XX Yes 2 \(\square\) No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give "natural" 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the 8 Clerk Railroad Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Appel Myrtle Marie Blight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Appel Jr. / Son 338 Regal Drive, Abingdon, Maryland, 21009 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State injury Parkwood Cemetery 8/30/2010 4 Donation 5 Other (Specify) Baltimore, Maryland of Fundal Service Liv 21. Signatur 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause one a aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final) Pnysician etastale ancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for 1 in the past 12 months? 4 Pregnant a 9 Unknown Pregnant at time of death Yes 2 No 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\bar{X}\) Residence 6 \(\sum \) Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

2 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David

only one) 29b. Signature and title of certifier

> w. MacPha. / , Bel Air, Maryland 21014 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

august 27,20,0

			For	State of M	arylan	-	artment of I		and M	ental Hy		1.0	27226
			1 State Registrar	(cot)		Cer	tificate of l	Death			nog. nom	10	27226
	Physicia		1. Decedent's Name (First, Middle, I	Last)	A.	DES				2. Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, o	give street and number)	ι,	161	4b. City, Town, o	r Location of	f Death	AUGUST	2.6 2 4c. County		10.30 A
	}		TRANSITION	5				ESVI		=		MRO	LC
	Funeral		· · · · · · · · · · · · · · · · · · ·	5. Sex 7. Ag 1 ☐ M 2 ☐ F		st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birt		g. Birthp Count	olace (State or Foreign try) MD
	Director		219-01-2558 Usual Residence of Decedent	X	91	Trs.				04/21/	1919		MD
	land shov	tor	10a. State 10b. County		10c. City	, Town or Loc	cation					1	0d. Inside City Limits
	Mary 28a-1 otifie	Director		/A	BA	LTIMO					-		1 🌠 Yes 2 □ No
	ith the 3a or t be n		10e. Street and Number	D.T.T.			10f. Zip Code	2.1			10g. Citizen of W		ntry?
	ath w	Funeral	7247 CONLEY ST	12. Was Decedent I	Ever in U.S	. 13. V	2122 Vas Decedent of H		in? (Spec	ify Yes or No-	US.		an Indian,
ဖွ	ter de , or ita imine	by F	1 Never Married 2 Marrie	Armed Forces?		I1	Yes, specify Cuba	an, Mexican,	Puerto R	ican, etc.)		k, White, e	etc.
8	ursaf tural" al Exa		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates.			☐ Yes 2 🔀 No				Specify:	WH.	ITE
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212	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 8	5+)		MEMAKER				OWN HO	ME	
Maryland 21215-0036	be filed antal Hyy ked oth c event	To Be	17. Father's Name (First, Middle, Las	st)				18. Mother	r's Name	(First, Middle, i	Maiden Surname)		
<u></u>	uld be I Ment narke	F	LOUIS		CHMON	ID I		LENA	-			HANI	DWERGER
Ma	12 should be file lith and Mental I 27 is marked o r traumatic eve		19a. Informant's Name/Relationship JEFFREY ADES/S			l	g Address (Street: 7 CONLEY					ate, Zip C 21224	
ē,	of Heal of Heal fitem		20a. Method of Disposition		20b. P		Piton (Name of ZI			ate	20c. Location -		
<u>E</u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				CEMETERY	0	8/29	/2010	BALTI	MORE	, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ij	21. Signature of Funeral Second Lin	ee)/			. Name and Addre		50		NSON & B		
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			shock, or heart failure. List onl	omplications that cause by one cause on each line	э.								Approximate Interval Between Onset and Death
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Box 687	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3 [Ectopic pregnance	у			23d. Date Mon		
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ds,	v requires the been signer should be									1 □ Y	∕es 2 □ No :	3 🗌 Prob	pably 4 Unknown
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<u>ta</u>	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 Oo	Hospital:			Oth	ace of Death	_				
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Division of Vital Records,	or Att	Certificate;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		iry - At hon c. <i>(</i> S <i>p</i> ec <i>ify)</i>	ne, farm, stre	et, factory, office		28	3f. Location (St City or Town	treet and Number n, State)	or Rural	Route Number,
ā			29a, Certifier 1 Certifying P	hysician: To the best of	my knowle	dge death o	ccured at the time	date and ni	ace and	due to the cau	see(e) and manner	ac state	d
	ne Hoo n 24 h ne Fur pleted	Medical	(Check 2 L Medical Exa	miner: On the basis of eaurse Practioner: To the	xamination :	and/or investi	gation, in my opinic	on, death occ	urred at the	ne time, date an	nd place, and due t	to the cau	ise(s) and manner stated.
_	Vithi Com	_	29b. Signature and title of certifier				29c. License	number		2	29d. Date signed	(Month, E	Day, Year)
			100		M.D			722		(AUGUST	26	2010
			30. Name and address of person wh	o completed cause of de	eath (Item 2	23a) (Type, Pr	int)	DEE D	2010				
	Stat	e	31. Date filed (Month, Day, Year) AUG 31 2	ARD 50 D Megistra 010 32 Registra	r's Signatu	1 50	Was !	ace pe	-1411	,,,,,	((LE) VICE		11 61 611
	Registra	r	AUG 312	UIU JOHN	~ /	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27,2010 Physician/ Month Curtis Lee Brown 2:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctor's Hospital Lanham 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. Director 238-88-5722 58 08/22/1952 Newburg. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Exam</u>iner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG Largo 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 New Orchard Place 20774 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Black Specify: 3 Divorced 4 Divorced Year or Dates. 72-76 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other that 12th Bus Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Edward Brown Jessie Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROWN portant: If item 27 is y injury or other train Forrestine Y. Brown / Wife 810 New Orchard Place; Largo, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of I Important: If it Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ponation 5 Other (Specify) Maryland Veteran Cem! 9/7/2010 Cheltenham, Maryland 21. Signature of Fund al Service 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road: Temple Hills, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between RESPIRATORY Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LUNG DISIEAS (SARCODISOSIS END STAGE Esquantiary list our citions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin HEMPTO SVE Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MDD 14094 08/30/2010 completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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AUG 3 1 2010

MU.

6130 OxonHP11 Rd., Suit & 301, OxonHP11, MD. 20745

DHMH 17 Rev 1/2001

Registrar

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Albert Bethea			of Maryland /	Depai	tment o	of Healt	n and	ivientai	Hygier		201	0	27229
	F	- For State tegistrar		Cen	ificate c	of Deali			I 2 Date	Reg. of Death	No.		ime of Death
Physicia		Decedent's Name (First, Middle,Last				Da	- h			th Death ust 24, 2	ay Year	- 1	535 hrs
Medical Examin		Albert	Jack	10			thea	cation of De		usi 24, 2	4c. County of De	eath	
		4a. Facility Name (if not institution, give University Hospital	e street and number)			Baltim		Jodalon or D					
	4		y 7 Age	(In vrs. la	st birthday)	If Unde	r 1 Year	If Under 24	4Hrs. 8. Da	te of Birth(ce (State or
Funeral Director				5 7		Months			Min. 11	04	52 Fo	reign Country)	MD
Director	L		M 2 F	37	Y	rs.							
ń	-	Usual Residence of Decedent 10a. State 10b. County	T	10c. City,	Town or Loc	ation							Inside City Limits
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yland -f sh	희	10e. Street and Number				10f. Zip	Code			10g	. Citizen of What (Country?	
Mar or 28s	Director		a				212	15			U.S.A	٠.	
-death with the Maryland or items 23a or 28a-f show must be notified at once.		4565 The Stran	12. Was Decedent	Ever in U.S	3 13. V	Vas Decede	nt of Hispa	anic Origin?	(Specify Y	es or No-	14. Race - A		ndian, Black,
ath wi	Funeral	1 X Never Married 2 Married	Armed Forces?		If	Yes, specif	Cuban, I	Mexican, Pu	erto Rican,	etc.)	White, et		
er der		3 Widowed 4 Divorced	If Yes, Give Year	X No	1	Yes 2	No	specify:			Specify:	Bla	ck
136 hin 72 hours afte e. than "natural", edical Examiner	2	15. Decedent's Education (Specify or	or Dates:	pleted)	16a. Deced	lent's Usual	Occupatio	on (Give kind	d of work do	ne 1	6b. Kind of Busine	ss/Indus	stry
2 hou	흹	Elementary/Secondary (0-12)	College (1-4 or 5		_	most of wor			e retired)	İ	Hilton	uot	- 1
36 thin 7 than than	힐	12th grade	lyr		Fo	od Se						пос	er
5-0036 filed within 72 Hygiene d other than the Medical	Completed	17. Father's Name (First, Middle, Last)						8.Mother's N Marga			aiden Surname)		1
21215-0036 July be filed within 72 hours after Nanial Hygiene. In marked other than "natural", ic event, the Medical Examiner.	Be	James Bethea J	r.					_				Make 7ie	Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Montal Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relationship (T	ype, Print) Pare	ents	19b. Mail	ling Address	(Street	and Number	rorRuralR	oute Numb	er, City or Town, S ore, Md	212	215
MD d 2 st lith an n 27		James & Margar	ine Beth	nea	1 456 Place of Disp				Date		20c. Location - Cit	y or Tow	n, State
re, s l an f Hea ff iter		20a. Method of Disposition 1 Burial 2 **Cremation 3	Removal from Sta		rematory or							-	
MO Page hent o		4 Donation 5 Other Specify	150		On-S				8/26/	50Tb	Balti	nore	, Ma
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Ponature of Funeral Service Licer	see		22 N	Name and	Address of	of Facility I Wes	t,	1 <i></i> i	imore,	M A :	21215
0 5 7 1 ii		23a. P. I. Enter the disease, or comp	Thomps	on) 4	1300	Waba	ish A	Ve, i	atory arres	t shock or heart	TA	pproximate Interval
Physician /Medical		faire. List only one cause on ea	ach line.					74011 40 541 4		,		В	letween Onset and Death
Examiner	28		Blunt Force Hea			omplicati	ons					+	
		or condition resulting in death)	Due to (or as a conse	equence of).								
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of	f):								
	min	cause. Enter Underlying Cause (Disease or injury that initiated										-+	
sit sd	Examine	events resulting in death) Last	Due to (or as a cons	equence of	r):								
executed an and al - transit	al	UNPENDED d.	AMENDED										
5 5 6 G	edic			ma of oron	20001		<u> </u>				23d. Date of de	livery	
Box 68760, e death certificate be the attending physici of for use as the buri	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne or preg	2	Fetal death	3 [Ectopic pr	regnancy		Month	Day	Year
x 68 h certi endin use a	Cia	past 12 months?	4 Pregnant at	time of de	ath 5	Other (Spe	cify)						
Bo: deat:	Physicia	1 Yes 2 No 9 Unknow	9 UNKNOWN					i Death		22a Did toh	pacco use contribu	te to the	cause of death?
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	by P	Part II. Other significant conditions	contributing to deat	h but not r	esulting in tr	ne underlyin	g cause gi	iven in Part	' I		2 ✓ No 3		
ires th									— <u> </u> ,	4a. Was a			sy findings available
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Recc The lav icate ha	Ĕ								1	Yes 2		Yes	2 No
tal Rec tian: The certificate		25. Was case referred to medical					26.Place	of Death (C	heck only o	ne)			
Vital hysician: this certif	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 Inpati	ent 2	ER/Outpati	ient 3 🗌 I	DOA (Other 1 1				Other:	
of Vital Records, ng Physician: The law require After this certificate has been sinneral director, page 2 should be	-	27. Manner of Death	28a. Date of Inj	ury Year)	28b. Time			y at Work?	Subi	Describe h	ow injury occurred beaten		
On endin ath. or: A	흝	1 Natural 5 Pending 2 Accident Investiga	Aug 22, 2010)	0335 hrs		_ 1Y	′es 2 ✓ N	10 1				
Division tal or Attendir rs after death. al Director: A	Ę	2 Accident Investiga 3 Suicide 6 Could no	28e Place of I	njury - At h	ome, farm, s	street, factor	y, office bi	uilding, etc.	28f. I	_ocation (S or Town, St	treet and Number ate) er Street, Baltimo	or Rural i	Route Number, City
Division of Vital I Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi rely filled in by the funeral director,	Certification:	4 Homicide determine	(0):00:37 31										
Division of Notin to the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Physic	cian: To the best of n	ny knowled	ige, death o	ccurred at th	e time, da	ate and place	e, and due t	o the cause	e(s) and manner at and place, and due	s stated. to the ca	ause(s)
To the within To the comple	Medical	(Check only 1 Certifying Physic one) 2 Medical Examine	er:On the basis of exa and manner stated	mination a	ind/or invest				ar rou at tile	, date c	29d. Date signed		
+ × + 5	ž	29b. Signature and title of certifier	4			29	oc. License				August 25, 2		Day, roar,
		Lameh Pourkeul.	MD				O.C.I	vi.⊏.			August 20, 2		
1)		30. Name and idd was of person who			n 23a)	111 Da	n Ctrons	. Baltima	ore MD 2	1201			
Y\		Pamela E. Southall, MD	Assistant Med			111 Pen		ı, Dailiiii0	JIC, IVID 2	. 1201			
	tate		33 Registr	ars Signat	ure	wed							_
Regis	ગાદ	AUG 3 1 201	U KAMMA	9	- 1971								

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year) State Registrar

anol a

Ana Rubio MD.

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 26, 2010

			State of Marylar				l Mental Hyg	jiene	27221
		_1	State Registrar	Cer	rtificate of E	Death		neg. No 2010	
	Physicia	_	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	24, 2010 Year	3. Time of Death 12:45 A M
	Medic	al .	Janice Ruth Bertsch 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of Deat	
	Examin	er				ver Spr			gomery
*****	Funeral		12700 Billington Road 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		297-03-9417 1 M 2 又 F 89	9 Yrs.	Months	110010	n. (Month, Day March 20	, 1921 Ohi	.0 "
	how how	٦	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	larylar 3a-f sl ified	ecto	Maryland Montgomery	S.	ilver Spr	ing			1 ☐ Yes 2 🔀 No
	the M	Ė	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23a	Funeral Director	12700 Billington Road			904			States
	death r item iner n	/ Fui	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	s after al", o Exam	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
2-0	hours natur dical	Sete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of w	vorking	16b. Kind of Business	Industry
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121	d with dygier ther t	o l	12 17. Father's Name (First, Middle, Last)	1 0	wner	18. Mother's N	lame (First, Middle,	Antique Maiden Surname)	
anc	be file antal H ked o c eve	힏	Leo Gottlieb Ahner				es Stephe		
Maryland	nd Me s mar umati		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street			; City or Town, State, Zi	p Code)
Σ	id 2 sh salth a n 27 is er tra		Barbara Ott/Daughter	1270	O Billing	ton Roa	d, Silver	Spring, M	
ore	of He of He If item or oth		20a. Method of Disposition 20b. 1 □ Burial 2 🔀 Cremation 3 □ Removal from State Mon	Place of Dispo cemetery, cre.	osition (Name of matory or other place tum, Inc.	e) Aug	gust 28,	20c. Location - City or	
Baltimore,	t. Pag tment rtant: ijury c						2010	Bethesda,	
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			1530 7	557 Wiscons	in Avenue	, Bethesda,	Maryland 208	y Chase, Inc. 14
			23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not ent	ter the mode of dyir	ig, such as card	iac or respiratory arr	est,	Approximate Interval Between
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	uted id ansit	ami	Cause (Disease or linjury Thoracic A		Aneurysm				
	death certificate be executed ne attending physician and ed for use as the burial-transit	Completed by Physician/Medical Examiner	resulting in death) Last Due to (or as a consecutive consecution) Due to (or as a consecutive consecution) Due to (or as a consecutive consecution) Due to (or as a consecutive consecution) Due to (or as a consecutive consecution) Due to (or as a consecutive	quence of):					
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6876	certific iding I	Ž.	F FEMALE: 23c. If yes, outcome of pregrant	nancy				23d. Date of de	elivery
Вох	eath of	icia	23b. Was decedent pregnant 1 Live Birth 2 Fe Fe Fe Fe Fe Fe Fe	f death 5	Other (specify)			Month	Day Year
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ဝ၁	e law s has t	Ē					— autoperfo perfo 1 ☐ Yes	rmed? death?	completion of cause of
E R	ificate h	Be	25. Was case referred to medical		26. F	Place of Death (C		ZATNOJ TER	3 Z 🗆 NO
Vita	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	ner: 4 🔲 Nursin	ig Home 5 🔀 Resid	dence 6 Other (Spe	cify)
of	ng Ph fter th ineral	ite:	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	wor	k?	28d. Describe h	now injury occurred	
ö	Attending r death. sctor: After oy the fune	tifica	2 Accident Investigation 3 Suicide 6 Could not be	home form s		Yes 2 No	28f Location (9	Street and Number or R	ural Route Number.
Division of Vital Records,	after after Direc	Cer	4 Homicide determined building, etc. (Spec	ify)	troot, factory, office		City or Tov	vn, State)	
	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical Certificate:	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examinat	wledge, death	n occured at the time	e, date and plac	e, and due to the ca	use(s) and manner as s	tated. e cause(s) and manner stated.
	the Hi hin 24 the Fu	Mec	only one) 3 Certifying Nurse Practioner: To the best of	my knowledge	, death occurred at t	he time, date and	d place, and due to th	e cause(s) and manner a	s stated.
-	Vith With Conf.		.29b. Signature and title of certifier		29c. Licens	37142		29d. Date signed (Mon	
			30. Name and address of person who completed cause of death (ite	am 23a) /Tuno				8-26-	
7			30. Name and address of person who completed cause of death (Its Geoffrey Colman, MD 1355 Pice	card Di	rive, #10	0, Rock	ville, Ma	ryland 2085	50
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign						
	Regist	rar	AUG 3 1 2010	y. Aga	A. Car				

DHMH 17 Rev 7/2009

		-	For State	te of Marylan	d / Depa Cer	artment of tificate of	Health and Death	Mental Hyg	giene 2010	27232
			Registrar 1. Decedent's Name (First, Middle, Last)		001	anoate or	Douth	2. Date of Dea	th	3. Time of Death
	Physicia Medic		STEFANIA BERN						t 29,2010	5:00A.M
P	Examin		4a. Facility Name (If not institution, give street an 1616 Hollingsworth			4b. City, Town, Joppa	or Location of Dear 2	th	4c. County of Dear Harfor	
	Funeral Director		5. Social Security Number 216 – 30 – 0283 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			1 9. Bir Pol	thplace (State or Foreign and
	ind ihow	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d, Inside City Limits
	Maryla 28a-f s atified	Director	Md. Harford	A	bingd	on				1 ☐ Yes 2 🙀 No
	with the 23a or 2		10e. Street and Number 2809 Bynum Overloo	k Drive		10f. Zip Code 21009			10g. Citizen of What Co	ountry?
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. ittem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S ed Forces? Yes 2 ♣ No ss, Give	1 1	Vas Decedent of Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer o Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
9	hours natura lical E	lete	15. Decedent's Education	r or Dates.		lent's Usual Occu		1	16b. Kind of Business	
21215-0036	within 72 giene. er than " the Mec	Completed by	(Specify only highest grade complete (0-12) Coll	ege (1-4 or 5+)	life. Do	eamstr eamstr	•	rking	Textile	
land	be filed vental Hygrked other		17. Father's Name (First, Middle, Last) Mikolaj Stankiewic	Z			18. Mother's Na	me (First, Middle, i	Maiden Surname) Zahorujko	
Maryland	2 should Ith and M 27 is mal traumat		19a. Informant's Name/Relationship (Type, Print John Bernacki (so			,			; City or Town, State, Zi	n, Md21009
Baltimore,	Page 1 and nent of Heal ant: If item: ary or other	-	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remova	20b. P	lace of Disno	sition (Name of natory or other place Sary Co	San	tember	20c. Location - City or	
altir	7 F F F		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	no				·		1 Home, P.A
ä	permit Depar Impor any in		From mount		1	201 Dui	ndalk A	venue B	altimore,	Md.21222
area.	Physician/		23a. Part 1. Enter the dise the, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death on each line.	n. Do not ente	r the mode of dy	ing, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
-	Medical Examiner		resulting in death)	ue to (or as a consequ						Years
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	cate be executed physician and the burial-transit	Examiner	that initiated events C. ——	ue to (or as a consequ	ence of):					
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Box	that the death ned by the atte detached for	Physician/M	1 Ves 2 No 4	Pregnant at time of d	leath 5	Other (specify)	icy		Month	Day Year
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of Vital Records,	w require s been si	Completed						24a. Was a	an 24b. Were au	topsy findings available completion of cause of
Rec	The law cate has page 2:	Com						autop perfor 1 □ Yes	med? death?	s 2 No
/ita	ysician: The is certificate director, pag	面	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 Inpatient 2	ED/0	Ot	Place of Death (Chi		ence 6 Sone	s Home
l of ∖	ding Phys h. After this funeral di	ate: To	27. Manner of Death 28a. 1 Natural 5 Pending		28b. Time of injury	28c. Inju	ıry at		ow injury occurred	<u> </u>
Division	or Attender free deat inector:	Certificate:	2 Accident Investigation 3 Sulcide 6 Could not be 4 Homicide determined	Place of Injury - At ho building, etc. (Specify,	me, farm, stre			28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
۵	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the	the best of my knowledge to the basis of examination	edge, death o	occured at the timi	ne, date and place, nion, death occurred	and due to the cau	use(s) and manner as stand place, and due to the	ated. cause(s) and manner stated.
	o the l	Me	only one) 3 Certifying Nurse Practi 29b. Signature and title of certifier			leath occurred at		lace, and due to the		stated.
	F > F 0		Wand Klee und	>					8/30/10	
			30. Name and address person who complete	d cause of death (Item	23a) (Type, F	rint)	1295 Barhman	e mo	21206	
	Sta	e	31. Date filed (Worth, Day, Year)	32. Registrar's Signat	ure	4				
	Registra	ar	AUG 3 1 2010 🚣	. <i>I</i> .	A Allo	Carried States				

	For State Registrar		State of Ma	aryland /	Depa / Cert	rtment of I ificate of I	Health Death	and Mei	ntal Hy	giene Reg. N		27	233
Physician/	1. Decedent's Name	(First, Middle, Las	st)						Date of De	eath	ay Year	3. Time	of Death
Medical	Thelma	Lee	Brown						08		23 2010		20 M
Examiner	4a. Facility Name (if n			_		4b. City, Town, o					County of Dea		
Funeral	5. Social Security Nur	nber 6. So	ehab Center	(In yrs. last b		Fort Was	If Under	24 Hrs. 8.	Date of Bi	rth	cince Ge	rthplace (Stat	
Director	239-46-42	2//	□м 2 Х] F	76	Yrs.	Months Days	Hours	Min.	(Month, Da	4 19	933 0	NC	
and show fat	Usual Residence of D 10a. State	10b. County		10c. City, To	wn or Loca	ation						10d. Inside	City Limits
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	MD F	Prince Ge	eorge's	0xon	Hill							1 🖾 🕆	Yes 2 □ No
th the	10e, Street and Numb			_		10f. Zip Code				10g. C	itizen of What C	ountry?	
ath will	7904 Clau	idia Driv	7E 12. Was Decedent Ev	er in II S	12 1/4	20745 as Decedent of H	lispania Ori	isin? (Specify	Van ar Na		USA		
by in property of	1 Never Married 3 Widowed 4		Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	No	lf '	Yes, specify Cuba	an, Mexicai	n, Puerto Rica	in, etc.)		14. Race - Am Black, Whi Specify: Bla	te, etc.	
21215-003 idhin 72 hours at lene. r than "natural" the Medical Exc		15. Decedent's Ed fy only highest gra		16	6a. Decede (Give kii	nt's Usual Occup nd of work done o NOT use retired)	ation during mos	at of working		16b. k	Kind of Business	Industry	
Vithin liene.	Elementary/Secon	iday (0-12)	College (1-4 or 5+ 4 years	·		NOT use retired) perviso:				Fed	leral Go	wernme	en t
nd ?	17. Father's Name (Fir	rst, Middle, Last)	+ years	10	10 50	PCI VISO.		er's Name (Fir	rst, Middle			Verme	
ylan Id be fill Mental Mental Iarked attic ev	Leavie Mo	Neill					E.	va McN	eil_				
Mar S shou h and 7 is m traum	19a. Informant's Nam	ne/Relationship (Ty	/pe, Print)		_	Address (Street						ip Code)	
re, I and 2 Healt tem 2	Albert Br 20a. Method of Dispo	own/Hust	pand	20b. Place	of Disposi	laudia I		xon Hi)745 .ocation - City o	r Town State	
mol		Cremation 3 Other (Specification)	Removal from State	ceme	tery, crema	tory or other plac	´ ;			l	Í		
Balti permit. F Departm Importa any inju	21. Signature of Fune			IAFLIN		Nat'l Co		ty Mars	2010 shall	Mar	ch Fune	ral Ho	ome
a a a a a a	Jan	et C. 1	Induson	t	42	17 9th 9	St. N	W Wash:	ingto	n, I	C 20011		
	shock, or heart	failure. List only or	olications that caused the cause on each line.	the death. Do	o not enter	the mode of dyin	g, such as	cardiac or res	spiratory ar	rest,		Approxin	Between
Pnysician/ Medical	Immediate Cause (Fil disease or condition resulting in death)	nal	a. Dua ta (au vii	ony		Kidh	ey ,	dise	95x			Grispit and	o Death O
Examiner			Due to (or a	consequence	1 01	1000	6					50	rea
kecuted and al-transit Examiner	Sequentially list cond and cause. Enter Underly	ing	b. Lue to (or as/a)	consequence	e of):	/	2	- 7	/	1-	_	,~,	<i>y</i>
ecutec and -trans	Cause (Disease or lin that initiated events resulting in death) La	jury	c. Due to (or as a	consequence	e of):	send	W-	000	354	1		5 !	ger
a uriz			d	-	,- /								
8760 tificate by ag the b	IF FEMALE:												
ox 6 Ith cer Ith ce	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 X	egnani	23c. If yes, outcome of 1 Live Birth 2	Fetal dea			су				23d. Date of de	livery Day	Year
O. Box 68' It the death certification to the attending stached for use as Physician/M	1 ☐ Yes 2 X 9 ☐ Unknown	No	4 ☐ Pregnant at t g ☐ Unknown	time of death	5 🗀 1	Other (specify)					WOM	Day	rea
P.O. s that t gened be deta	Part II. Other significa	ant conditions co	ontributing to death but	t not resulting	g in the und	derlying cause giv	ven in Part	I.	23e. Did t	obacco ı	use contribute to	the cause o	f death?
rds,								— L	1 🗆	Yes 2	□ No 3 □ F	robably 4	Unknown
Records, The law requirer cate has been six page 2 should t						_			24a. Was auto		-tAL-O	completion o	s available f cause of
I Re in The ifficate or, page	25. Was case referred	t∕ o medical				ne Di	see of Dear	th (Check only	1 Yes		o 1 🗆 Ye	s 2 X No	
Vital hysician hysician his certifi director	examiner? 1 Yes 2	No	Hospital:	 nt 2 □ ER/0	Outpatient	Othe				dence f	Other (Spec	rifyl	
ng Ph fter th ineral	27. Man er of Death	5 Pending	28a. Date of injury (Month, Day,	28b	. Time of injury	28c. Injury work	y at				y occurred	ary)	
ivision of or Attending P after death. Director: After t in by the funera	2 Accident 3 Suicide	Investigation 6 Could not be	28e. Place of Injury	. At home	form street	M 1 🗆	Yes 2 🗆	-				-	
	4 U Homicide	determined	building, etc.		iariii, stree	i, ractory, office			Location (S City or Tox		d Number or Ru)	ral Houte Nui	mber,
he Hospita in 24 hours ne Funeral pleted filled	29a. Certifier 1 (Check 2 L	Certifying Phys	ician: To the best of m	y knowledge	e, death oc	cured at the time,	, date and	place, and du	e to the ca	use(s) ar	nd manner as st	ated.	manner stated
the lithin 2 or the long the long the long left	only one) 3 29b. Signatule and title	Certifying Nurs	e Practioner: To the be	est of my kno	wledge, dea	ath occurred at the	e time, date	and place, an	d due to th	e cause(s	s) and manner as	stated.	
5 3 5 8		2	1			29C License	- 7.45°	535			te signed (Mont \$25	n, Day, Year)	
	30. Name and address	s of person who co	ompleted cause of dea	ath (Item 23a)) (Type, Prir	nt)	- /			U	0,00	, 10	
10	Laxmi N.	Berwa MD	7700 01d	Branc	ch Av	e. Clint	on, N	√D 2073	35				
Registrar	31. Date filed (Month, AUG	3 1 2010	32. Registrar	s Signature	par								
DHMH 17 Rev 7/2009				-									
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Anthony Davon Barnes	State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ificate of Death		Reg.	No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)	Davon R	oarnes		2. Date of Death	av Year	3. Time of Death 0124 hrs
		4a. Facility Name (if not institution, give Prince Georges Hospital	street and number)	4b. City, Towr Cheverly	, or Location of Death		4c. County of Death Prince George	
Funeral		Social Security Number	7. Age (In yrs. las			8, Date of Birth (MM/DD/YYYYY 9. Birt	tholace (State or
Director		579252489 1X	v 2 F \(\(\c)\(\c)	Yrs. Months	Days Hours Min.	08/09/	Foreig	untry) D.C.
any		10a. State 10b. County	10c. City, To	own or Location	^			10d. Inside City Limits
land f show	ō	MD P.G.	CF	APITAL H	EIGHT !	2		1 X Yes 2 No
h the Mary 3a or 28a- otified at	I Director	10e. Street and Number	avenue	10f, Zip Coo	743	10g.	Citizen of What Cour	itry?
r death wit or items?	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
ırs afte ural", miner	by	45.0	Yes, Give Year or Dates: y highest grade completed) 1	1 Yes 2 X	No specify:	ork done I16	Specify: Sb. Kind of Business/Ir	JUCK ndustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien is fined matural?, or items 23a or 28a-f show any important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working			n/Q	rado i y
5-0(iled wi Hygier I other the M		17. Father's Name (First, Middle, Last)	C 2050		18.Mother's Name	(First, Middle, Maid	den Surname)	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	o Be	19a. Informant's Name/Relationship (Typ	GYEEN	19b. Mailing Address (S	reet and Number or R	11 Bouts Number	arnes	7:- 0-4-)
, MD 2 and 2 shou ealth and N em 27 is n	To	Zakia New k	irk/Mother	918 NOVO	avenue	, CAPT., F	HEIGHTS O	10.,20743
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		1 X Buriat 2 Cremation 3		matory or other place)	Cernetery,	212	Print 2001	Town, State
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	· Cl	22. Name and Addr	ess of Facility	1110	101 / 101d	St. N.E.
ii. iii. Degrae		//////	my	B.K.H	C	eral How		
Physician // Medical		23a. Part Enter the disease, or complice failure. List only one cause on each	ations that daused the death. Do	o not enter the mode of dyi	ng, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		1947 147 1 1 44 3	ultiple Gunshot Wounds le to (or as a consequence of):	3				Death
		Sequentially list conditions, b						
	iner	cause. Enter Underlying Cause	ue to (or as a consequence of):					
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):					à la la la la la la la la la la la la la
760, frate be executed physician and the bunial - transit		d. UNPENDED	AMENDED					
760, ficate be g physici the buri	/Medical	IF FEMALE:	23c. If yes, outcome of pregnar	ncy			23d. Date of delivery	
687 certific rding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of death		Ectopic pregnan	су	Month Da	ay Year
Box 68 e death certificate attending ed for use as	Physician	1 Yes 2 No 9 Unknown	Pregnant at time of death Unknown	5 Other (Specify)				
P.O. es that the gned by the detache	by P	Part II. Other significant conditions	ontributing to death but not resu	liting in the underlying caus	e given in Part I.		co use contribute to the	
S, P puires t	ed b						No 3 Proba	
cords, law requir has been s	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
tal Rec cian: The certificate ector, page		25. Was case referred to medical		00.51	(5 4 (2)	1 Yes 2	No 1 ✓ Yes	2 No
Vital hysician this cert	o Be	annual and	pital: 1 Inpatient 2 ✔ ER		ce of Death (Check or		idence 6 Other	
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed its after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transi	+1	27. Manner of Death	28a. Date of Injury 28	Bb. Time of Injury 28c. In	jury at Work? 2	8d. Describe how i		
Sion ttendi death. rtor:	atio	1 Natural 5 Pending 2 Accident Investigation			Yes 2 No	ubject shot		
Divis	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home (Specify) Local Street	e, farm, street, factory, office		or Town, State)		Al Route Number, City
Hospi 24 hou Funer cely fil		4 Homicide	To the best of my knowledge,	death occurred at the time.			Young Street, SE,	
To the within 2 Worthin 2 To the 1	Medical	one) 2 Medical Examiner: 0	n the basis of examination and/ond manner stated.	or investigation, in my opini	on, death occurred at	the time, date and p	place, and due to the	cause(s)
1 2 1 2	ž	29b. Signature and Atle of certifier			nse number	1	d. Date signed (Monti	h, Day, Year)
			// M)		C.M.E.	Αι	ugust 18, 2010	
		 Name and address of person who con Russell Alexander MD. As 	npleted cause of death (Item 23) sistant Medical Examine		t, Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's lignature	ach		OCME		
Regist	rar	AUG 3 1 2010	some b. 14			JUNE		

Amend Item 2 State of Maryland / Department of Health and Mental Hygien [] |] | Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ILN (+ ANGUS! 1.30A M Medical 4a. Facility Name (if not institution. give street and number) Examiner City, Town, or Location of Death 4c. County of Death ross MONTGOMERY HOSPITA iller Prin 9. Birthplace (State or Foreign Sex 1 M 2 D F 8. Date of Birth Month Day, Year), 1-8 Social Security Number 7. Age (In yrs. last birthday) 2 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** Min. 217-08-3495 Serul Korea **Director** Usual Residence of Decedent 10c. City, Town or Location "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Silver MD MONTGOMERY OPTINC 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UCCANEER COURT 707 2090 USF 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Lefter— Carriel 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (14 or 5+) POSTAL Be 17. Father's Name (First, Middle, Last) 3, Mother's Name (First, Middle, Maiden Surname) HYUN HYO KON G မ BONG Hee MN (? Kang 19a. Informant's Name/Relationship (Type, Print) (W) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UN GAE CHUNG enviter 707 Dilver Opring Mi) 20904 MUET 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date OINEY, Maryland 1 Burial 2 Cremation 3 Removal from State 8-23-2010 NorbeckMemorial 4 Donation 5 Other (Specify) FUNERA Signature of Funeral Service License 22. Name and Address of Facility gov 10220 Guifford WICH Koas 2074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line **Ventricular Fibrillation** Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated see or linjury Examine Due to (or as a consequence of, pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 No 1 🗌 Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and icense number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03 corgia Avenue 31. Date filed (Month, Day, Year) Registrar's Signa State **AUG 31** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a/Nacility Name (if not institution, give street and number) **Examiner** Death If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Yea 10 03 192 Age (In yrs. last birthday. **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 XF Hours 218.18.3306 88 Country) MD Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Mill Mindsor Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA Road Main Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes. Give Specify: NHITE 3 ₩idowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dental Assistant Dentistry 2 vears 12th grades Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Plowman)ames Vista Si Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Corbett Ridge Hedgesville 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9 2010 Ridge Cemetery Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Vaugno C. Greene Fryneral SVG Pandallstown MD 21133 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a Part 1. Enfer t shock, or Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 000 MOSPIC မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No injury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sig 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 32. Registrar's State AUG 3 1 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 130AM Medical Facility Name (if not institution, give street and number) County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Age (In yrs. 57 9. Birthplace (State or Foreign **Funeral** Months Country 220-62-9968 **Director** 11/53 Usual Residence of Decedent or 28a-f show notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/AMD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a my injury or other traumatic event, the Medical Examiner must be a Completed by Funeral 21231 USA 20 N. Maderia St. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. African etc. 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 X Widowed 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working _life.,DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Construction Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Doris Mae Murray Howard L. Chew, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20 N. Maderia St., Balt., MD 21231 Jamilla Spriggs/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c_Location - City or Town, State 9/2/10 Bayview Crematory 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Balt.,MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitHari P. 5126 Belair Rd, Balt. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) 124 hours a 'er death. e Funeral Director. After this certificate has been signed by the attending physician : leted filled | by the funeral director, page 2 should be detached for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ☐ Pregnant ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Knknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 26. Place of Death (Check only one) atunt Hospital MUSDIZ မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29d. Date signed (Month, Day, Year) 8 2010

State Registrar 31. Date filed (Month, Day, Year)

23a) (Type, Print)

cause of death (Item,

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theodore COX Jr. August 17:53 M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deat Sinai Hospital of Baltimore N Baltimore 5. Social Security Number 8. Date of Birth (Month, Day Yes Funeral . Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Country Maryland Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside Gity Limits filed within 72 hours after death with the Maryland by Funeral Director 1 Yes 2 No yaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Division Head Pinlico Race Track Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည pe neodore (D Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mary Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) KENTKHOWN 1 🗌 Burial 2 🖼 Cremation 3 - Removal from State Catonsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ≺Physician/ disease or condition resulting in death) Intracerebral days Medical Due to (or as a consequence of) **Examiner** hypertension Sequentially list conditions, Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ atrial fibrillation, enlarged 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Ninpatient 2 - ER/Outpatient 3 - DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 - Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner T. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check RES-000 August 25, 2010 completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Registrar

DHMH 17 Rev 7/2009

g

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08/26/2010 4:15 A Jeanette G. Chamberlain 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Riderwood Nursing Facility Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🔼 F Days Months 12/23/1923 ND 303-26-8091 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 United States 3156 Gracefield Rd. #113 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No If Yes, Give Year or Dates: 1432 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2KNo Specify: 3 XWidowed 4 ☐ Divorced 1982 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NTH 5+ Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Dulin Goodwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3156 Gracefield Rd. Silver Spring MD 20904 Jeanette G. Chamberlain- Self 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 08/26/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility M0038Z 933 Gist Ave. 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silver Spring MD Approximate Interval Between Onset and Death Immediate Cause (Final Mediastinal Tumor disease or condition resulting in death) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Directo

Funeral

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Completed

Be

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Aaron

Examiner

Funeral

Director

28a-f show

death

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the World all Eventure I has be not liked at

h and Mental h

Health a

Important: If it any Injury or c

Examiner and attending physician Physician/Medical for ed by the detached i signed by the þ Completed has Be Certification: To

law requires that the death certificate be executed

or Attending Physician: The

ours after death.

reral Director: A

To the Hospital within 24 hours a To the Funeral L

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. In the control of the cause (Disease or injury that initiated events resulting in death) Last	b c d	Due to (or as a consequ								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	2	f yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of d 9 Unknown	death 3 Ecto	pic pregn er <i>(specif</i> y			()	23d. Date of de Month	l elivery Day	Year
Part II. Other significant condition Breast Cancer	ns contribu	iting to death but not resu	ilting in the underly	ing cause	given in Part I.	248	a. Was an autopsy performed?	24b. Were a prior to death?	robably utopsy find completion	4 Unknown
25. Was case referred to medical					26. Place of Dea	ath (Check	(only one)			
examiner? 1 ☐ Yes 2 🕱 No	Hospi	ital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[] DOA	Other: 4 Nursing H	lome 5	Residence	6 ☐Other (Sp	ecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation 2	8a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. I	njury at Vork? □Yes 2□No	28d. Des	scribe how inju	ry occurred		
3 Suicide 6 Could r 4 Homicide determi		8e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa	ctory, offic	ce	28f. Loci City	ation (Street a or Town, Stat	nd Number or F e)	Iural Route	Number,
29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner:	on: To the best of my known on the basis of examinar and manner stated.	wledge, death occi tion and/or investig	irred at th ation, in n	e time, date and plac ny opinion, death occ	e, and due urred at the	to the cause(e time, date ar	s) and manner and place, and du	as stated. e to the ca	use(s)
29b. Signature and the objectifier	2/11			29c. Lic	ense number		29d. Da	ate signed (Mor	th, Day, Ye	ar)

D24093

08/26/2010

State Registrar

Medical

3110 Gracefield Rd. Silver Spring MD 20904 Parkhurst,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date

		•	For State Registrar		State of IVIa	aryianu		tificate of				Reg. No	0010	27210
	Physicia	ın/	1. Decedent's Name				-				2. Date of De Month	ath Da	ay Year	3. Time of Death
	Medic Examin	al	Micha 4a. Facility Name (if)		street and number)	Cro	wley_	4b. City, Town,	or Location		August	29,	2010 Year 2010 County of Death	5:45 A ^M
أمرر	ZAGITILI		•		e Casey Ho	use		Rockvi					lontgomer	
	Funeral Director		5. Social Security Nu 039-24-13	31	ex 7. Age	(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir September	r 9°,1	9. Birth Cou	nplace (State or Foreign ftry) Ie Island
	f show	tor	Usual Residence of 10a. State	10b. County		10c. City, 7	Town or Lo	cation		_				10d. Inside City Limits
	Mary 28a-	Jirec	MD 10e, Street and Num	Montgome	ry	Darr	nestor	Vn 10f. Zip Code				10- 0	itizen of What Cou	1 🗆 Yes 2 🛣 No
	with the	Funeral Director	12909 Rif		Court			20878				USA		arta y r
Š	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show the other than "natural", or items 23a or 28a-f show ite event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marri	ed 2 🕅 Married	12. Was Decedent E Armed Forces? 1 A Yes 2 I If Yes, Give	10/	22	Was Decedent of I f Yes, specify Cub			cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh	
2-003p	hours a natural' Jical Ex	Completed	3 Widowed 4	15. Decedent's Ecify only highest gra	Year or Dates. ducation		16a. Deced	dent's Usual Occu	pation		ing		Kind of Business I	ndustry
1212	ithin 72 iene. r than " the Med	Comp	Elementary/Seco		College (1-4 or 5	i+)	Ìife. D	ONOT use retired	danny mo	JSLOF WORK	ng			tes
ylandz	should be filed within 7/ and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (F John Jos		owley					ther's Name				
Mary	age 1 and 2 should be file ant of Health and Mental I it: If item 27 is marked o y or other traumatic eve		19a. Informant's Na	me/Relationship (T)	vpe, Print)		19b. Mailir	ng Address (Stree	t and Num	ber or Rura	l Route Numbe	er, City o	r Town, State, Zip	Code)
ຜົ	and 2 sealth sem 27 sem 27 sher tr		Marsha F.		/ Wife	Jook Die					t Darne			
HOL	age 1 aent of H		1 🖾 Burial 2 [Removal from State			sition <i>(Name of</i> P itings Oak emetery					•	
Baltimore,	permit. Page 1 a Department of h Important: If ite any injury or of		21. Signature of Fur				_ R ²	Name and Addr	ess of Fac	hrev	Funera	1 Ho	me, Inc.	Rockville
			23a. Part 1. Enter ti shock, or hear	he disease, or comp t failure. List only o	plications that caused ne cause on each line	the death.								Approximate Interval Between
F	nysician/ Medical		Immediate Cause (I disease or conditio resulting in death)		a. Cholan			ma				United States Government Maiden Surname) anahan ar, City or Town, State, Zip Code) estown, Maryland 20878 20c. Location - City or Town, State Gaithersburg, Maryland 1 Home, Inc. Rockville 11e, Maryland 20850 rest, Approximate		
	Examiner	<u>~</u>	Sequentially list cor	nditions,	b		0							
	rted d ansit	amine	if any, leading to im cause. Enter Under Cause (Disease or I that initiated events	lying linjury	Due to (or as a	a conseque	nce ot):							
_	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) L	Last	Due to (or as a	a conseque	nce of):							
20/2	ficate by growing by the by th				l d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregna Other (specify)	ncy					•
л Э	that the ned by t e detach	by Ph	Part II. Other signif		ontributing to death b	out not resul	ting in the u	underlying cause	given in Pa	ırt I.				the cause of death?
rds,	equires een sig nould b	eted	Нур	ertension	n							_		robably 4 🔀 Unknown
Heco	The law rate has b	Completed									24a. Was auto perf 1 🗆 Yes	DSV	prior to d	topsy findings available completion of cause of
Ita	sician: certific irector,	Be	25. Was case referre examiner? 1 \(\sum \) Yes 2 \(\begin{center}2\)		Hospital:	205	D/O-+		hor	eath (Checi			S V Other (Spee	Hospice
Division of Vital Records,	iding Phys th. After this funeral d	cate: To	27. Manner of Death 1 A Natural 2 Accident		28a. Date of inju (Month, Day	ry 2	88b. Time of injury	wo			28d. Describe			ny nospice
JIVISIO	al or Atter s after dea l Director d in by the	Certificate:	3 Suicide 4 Homicide	6 Could not b determined	e 290 Place of Init	ury - At hom c. (Specify)	ne, farm, str	reet, factory, office)		28f. Location (City or To		nd Number or Rui e)	ral Route Number,
	Hospit 24 hour Funera leted fille	Medical	29a. Certifier 1 (Check 2 only one) 3	☐ Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination a	and/or inves	stigation, in my opi	nion, death	occurred a	t the time, date	and place	e, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and		2 1	Δ	20	29c. Licer	ise numbe	r		29d. D	ate signed (Month	
			30 Name and add	ass of person who	completed cause of d	leath (Item 2	C/C/		151	108		08/2	29/2010	
1)			Diane R	uckert,	C.R.N.P 60	001 Mi	incas	ter Mill	Road	Rock	ville,	Mar	yland 20	855
	Sta Registr		31. Date filed (Mont.	7 1 2010	32. Registra	ar's Sanatu	POL	w.						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0100 M 6 2010 heresa, A. Campion 26 /Medical 4a. Facility Name (If not institution, give street and number)
GEORGES PETTING PARKLEY
LEOT WENT WITH RE 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Protimere, MD
If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 1 F 219-30-2097 75 Director Sept. 10,1934 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h. County 10c. City, Town or Location nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "notion Examiner must be notified at 1 ☐ Yes 2 TrNo Director MD. Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6390 Hawthorne Ave 21075 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th School Custodian Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Miller, Sr. Minnie E. Semmont ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Oliver Campion/Husband 6390 Hawthorne Ave., Elkridge, Maryland 21075 | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State | Aug. 28,2010 | Elkridge, Maryland 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee Talista 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Putai Jany **Physician** Macro adenma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Adrenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Lesdellan that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by nellute 1 | Yes 2 | No 3 | Probably 4 | tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, death.

within 24 hours after death

To the Funeral Director:

Certification: To 27. Manner of Death

Medical

1 Watural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

State Registrar

29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

and manner stated.

29c. License number D 31464

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes

2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. ENTAW ST Shile 308 BALTIMORE MD 21201 A. HASHMI MD

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Pending investigation

6 Could not be determined



arol Cooke		I- For State	Sta	te of Maryla		partment of certificate of		and Mental		eg. No.	2010	27242	
Physicia	n/	Registrar 1. Decedent's Name (Fi	irst, Middle,	Last)				<u>-</u>	2. Date of Dea Month		Year	3. Time of Death	
Medical Examir							Ah City Town	August 2 1b. City, Town, or Location of Death			County of Death	0755 hrs	
			a. Facility Name (if not institution, give street and number) 1163 Naticoke Street					Baltimore			n/a		
Funeral		5. Social Security Numb	5. Social Security Number 6. Sex 7. Age (In			rs. last birthday)	If Under 1 \			th(MM/	DD/YYYY) 9. Bir Foreig		
Director		217-66 - 4855	5	1 M 2XF	53	Υ	rs. Months [Days Hours I	Min. 4-27-	4-27-1957 Country)			
any	F	Usual Residence of Dec	City, Town or Loc	ation				10d. Inside City Limits					
* .		MD n/a				Baltimore City				1 🔀			
larylan 18a-f s	Director	10e. Street and Number				10f, Zip Code				0g. Citiz	zen of What Cou	ntry?	
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e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she rraumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married	2 Man	12. Was Dec	orces?	If		Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	 Race - Ameri White, etc. 	can Indian, Black,	
ter dez		3 Widowed		1 Yes rced If Yes, Give Yea	2 X N	X No 1 Yes 2 No specify:					Specify: Tul	hite	
ours af atural	d b	15. Decedent's Educa	tion (Specif	or Dates: fy only highest grad	de completed						(ind of Business/		
215-0036 be filed within 72 hours as nual Hygiene. rked other than "natural ent, the Medical Examin	olete	Elementary/Seconda	ary (0-12)	College (1				me. DO NOT 436	retiredy				
-003 d withingiene.	Completed	12 17. Father's Name (Firs	st, Middle, L	ast) n/	a	Wa	itress	18.Mother's Na	ame (First, Middle, I	Maiden	Food S Surname)	ervice	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Bec	Edward Charles Cooke Alice Amelia Czinalla											
21 hould nd Mei is man	۵	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
rre, MD 2 s 1 and 2 shou ff Health and N If item 27 is r	ŀ	Timothy Ba		dner/ So		Db. Place of Disp			et Baltim		City, M ocation - City or		
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Baltimore, permit. Pages 1 at Department of He Important: If ite	1	4 Donation 5 Other Specify: Atlantic CrematoryLLC Aug, 30, 201 Glen Burnie, MD 21. Signature of Funeral Service Licence 22. Name and Address of Facility Ambrose Fuenral Home, Inc.											
Lit In Dept.		NIM	()	Kon	JAY.	1	328 Sulp	hur Spri	ing Road	Arbı	itus, MD	21227	
Physician		failure. List only one cause on each line.										Approximate Interval Between Onset and	
Examiner	ĺ	Immediate Cause (Fina or condition resulting in		a. Atheroscler			isease					Death	
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Box e death the attu			Unkn	9 UIKIK					T				
P.O.	P P	Part II. Other significa Chronic Alcoh		ns contributing to	death but n	ot resulting in the	underlying cau	se given in Part I.		_		the cause of death? pably 4 Unknown	
ds, F equires een sign	eted	Omorno / ticon	ionorn			-			24a. Was			topsy findings available	
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tal Recions The secrificate rector, page		25. Was case referred to	to medical				26.PI	ace of Death (Che		2		2 110	
Vita	To Be		No	Hospital: 1	npatient 2						nce 6 🗸 Othe	Scene	
n of ding Ph		27. Manner of Death 1 ✓ Natural 5	Pendir		of Injury , Day,Year)	28b. Time o	· · · · 1 _	Injury at Work? Yes 2 No	28d. Describe	how inju	iry occurred		
Division of Vital Records, tal or Attending Physician: The law requir rs after death. 1a Director: After this certificate has been siled in by the funeral director, page 2 should be	Cati	2 Accident	Investi	igation 28e Plac	e of Injury - A	At home, farm, str			28f. Location (Street a	nd Number or Ru	ral Route Number, City	
Divi pital or ours afte eral Dir	Certification:	3 Suicide 6 4 Homicide	Could						or Town, S	state)			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C			iner:On the basis	of examinatio				and due to the caused at the time, date				
\$ £ \$ £ 8	ŝ	and manner stated. 29b. Signature and title of certifier			tatou.	29c. License number					29d. Date signed (Month, Day, Year)		
		mes.					0.	C.M.E.		Aug	ust 27, 2010 		
		30. Name and address Ana Rubio MD		vho completed caus stant Medical I	,	· ·	Street, Balti	more, MD 212	201				
	ate	31. Date filed (Month, D	Day, Year)	32. Re	gistrar's Sign								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Yea 20 **Physician** Sa P M 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner nesis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 😿 F 8 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evanders must be notified at 1 ¥Yes 2 □ No Director GrEENBelT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Mandar by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; if item 27 is marked other the any Injury or other treasment. S. lministrator TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) olelin 1909 Mandan # Michael Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hill CEMETERY KINGHAM. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 20002 Wash emu Approximate Interval Between Onset and Death 23a. Par 1 Immediate Cause (Final Physician 100 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has t director, page 2 s autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manuar of Daath 28b. Time of 28d. Describe how injury occurred 28c. Injury at/ Work? After Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af Acident 1 □Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who complete

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9 East West

29d. Date signed (Menth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:10AM ROBAH ANDERSON DULL, Jr. Medical 20,0 ugust 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Arundel Anne Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 - F Hours (Month, Bay, Year) Country) 238 30 9306 Director 84 NCUsual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Severna Park 10e, Street and Number 10g. Citizen of What Country? Funeral 376 North Drive 21146 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 1945 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Independent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eventoe. and Mental Fisher is marked o ၉ Robah Anderson Dull, Sr. Lilly Holder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Owen - daughter North Drive <u>Severna Park, MD</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/10 Glen Haven Mem Pk Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of rup al Sanice Licensee Drive Pasadena, 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY disease or condition ARTERY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year signed by the a d be detached t Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown eral Director; After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after c Funeral Direct 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🖂 within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18+23,2010 D57531 mas.

State Registrar Hwy

nillersvice

8601 Veterans

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neg

31. Date filed (Month, Day, Year)

AUG 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ eaver Month tortence -ich 300 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death General Howard Count Howar Columbia 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, 8 26 1 🗆 M 2 😾 F Months Days Min Director 239-46-7719 80 Usual Residence of Decedent show 10a. State at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director be notified 28a-f Columbia 1 ☐ Yes 2 ☐ X o MD Howard 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral "natural", or items 23 21046 U.S.A. 9552 Moonrider Lane Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items any or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes X☐ No Specify: Black Specify: Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Housewife</u> Home 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Wilbert Lee Elizabeth Boyett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fisher Drive, York, PA17404 Judy Deaver-Daughter Important: If item ? any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Park 8/31/2010 Memorial Woodlawn, Sign ture & Funeral Service Licenses 22. Name and Address of Facility
Narch F/H West 300 Wabash Baltimore, Md 21215 Ave, 23a. Pa 1. Enter the disease, or complications that obused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each lin Im Jediate Cause (Final Onset and Death Physician/ sease or condition resulting in death) Medical Due to (or as a con-Examiner tension 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending iniury work 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3 [29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State AUG 3 1 2010 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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			1. Decedent's Name (First, Middle, Last)								Date of Death 3. Time of Death					
	Physici		Annie			M. Dixon			า	Month Day Year 08 25 2010 11:45am				• 15 am		
	/Medic Examir			(If not institution	, give street and nu					4b. City, Town, or					: 4Jam	
1			5120 Hazelwood Ave Baltimore													
	Funeral		5. Social Security		6. Sex	7. Age (In yrs	. last birthday)	If Unde	r 1 Year Days	If Under 24 Hrs	8 Date of Birt	h v Year	9. Birthp	lace (Sta	te or Foreign	
п	Director		227-40-	-6097	1□ M 2√ F	80	O Yrs.	INIOIILIS	Days	Flours Will.	n. (Month, Day, Year) Country) O9 O5 29 VA					
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	9 W	5	MD	N A	4		Balti									
	igh t	吉	10e. Street and N	umber				10f. Zi	p Code			10g. Citizen of	What Coun	try?		
	ath v	B	5120 Ha										S.A.			
	ar de	Funeral Director	11. Marital Status		Armed Fo	12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto			pecify Yes or No o Rican, etc.)	Bla	ce - Americ ck, White,					
36	S off	by F		rried 2 Marri 4 Divorced	If Yes, Gir	2 No		1 🗆 Yes	2 X No	Specify:		Specif	y: B1	ack		
Maryland 21215-0036	n 72 hours efter death with the Marylen "naturel", or flems 23a or 28a-f show edical Examiner must be notified at	8	2 X Midowed	15. Decedent	Year or D	ales.	16a. Deced	lant's He	ial Occur	nation		16b. Kind of B	usiness/In	dustry		
15	in 72	Completed		ecify only highes	t grade completed)		(Give	kind of wo	ork done	during most of wo	rking	ing				
7	filed with Hygiene. Ither ther	E	12th qu		College (College (1-4or 5+)					Epstein's Dept Co.					
b	Hygie other	Be C	17. Father's Name				ВСРС	L CIII			ne (First, Middle,			ДСР.		
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ar _y	2 should be filed within end Mental Hygiene. is marked other than sumatic event, the Ma		19a. Informant's				19b. Mailir	ng Addres	s (Street	t and Number or Ru		er, City or Town	State, Zip	Code)		
	s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ma		Dobes I	livon I	ac-Daug	htor	5120	L L	7011	vood Ave	P-1+	imoro	ма	2120	06	
5	f Her fern othe				.ee-Daug		Place of Dispo	sition (Na	me of		Date	20c. Location	City or To	wn, State	,	
Ę	Peges nent of t nt: if ite				3 □Removal from	State		•		,	0/20/2	010 0-		D# -	1 1 M -	
Baltimore,	본 원 급 .		4 Donation 5 Other (Specify) Garrison Forest Vet 8/30/2010 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility March F/H West													
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		\Box	23a Part1 Enter	the disease, or	complications that of	aused the dea							110 2	Approxin		
	Physician	М	shock, or he	art failure. List	complications that conly one cause on e	ach line.	20 1101 011	0. 1.10 1.10	ac or ay	ng, outin at our dia	or roop natory a	1000		Interval E	Between nd Death	
	/Medical	4	Immediate Cause (Final disease or condition													
н	Examiner		disease or conditi resulting in death	ion)	a	Due to (or as a consequence of):										
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	death certificeta ba anscuted e ettending physician and ad for use es tha burial-trensit	Examiner	Sequentially list of	onditions.	b. ———	b										
oʻ	a axe an al		Sequentially list of any, leading to it cause. Enter Und Cause (Disease of	immediate derlying												
68760,	eta bu	edicai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									1				
9	artifice ing pl	Z E	1650tting in Obatin) Last													
Вох	eath ce ettendii I for use	Physician/														
<u>o</u> .	t tha dea by the e tached f	380	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							ven in Part I.	23b. Did t	obacco use co	ntribute to	the caus	se of death?	
<u>P.</u>	ed by detac										1 🗆 '	Yes 2 No	3 ☐ Prot	ably 4	Unknown	
	S 6 8	þ	24a. Was an autopsy performed?										Oth Management Carlings			
of Vital Records,	v require been si should I	Completed										ava	o. Were autopsy findings available prior to			
ec	BW BS C S S	츁									completion of cause of death?			Ji Cause		
<u>=</u>	The i	5									101	es 22No	10	Yes 2	2□ No	
/ita	Physician: this certific		25. Was case refe examiner?	rred to medical					1.		th (Check only o	ne)				
=	hysic his o	유	1 ☐ Yes 2				ER/Outpatien		_	4 LI Nursing H	ing Home 5 Aesidence 6 □Other (Specify)					
_	ding Ph h. After th funerel	Ë	 Manner of Dea Matural 	ith 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury		28c. Injui Woi		28d. Describe how injury occurred					
Sio	Attending or death. •ctor: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	investig	ation	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Division	or Attend after death Director: /	ŧ	4 ☐ Homicide	determi	ned 286. Place											
Ω	ital or railed i			-/												
	Hospital 24 hours Funeral tely filled	edical	29a. Certifier (Check only one)	2 ☐ Medical E	Phyaiclan: To the examiner: On the ba	sis of examina	owledge, death ation and/or inv	occurred estigation	l at the tir n, in my c	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and ma date and place,	anner as st and due to	ated. the caus	e(s)	
	e i e e			d title of certifier	and mann	er stated.		29	c. Licens	se number		29d. Date sione	d (Month	Day. Yes	r)	
	To vit								29d. Date signed (Month, Day, Year) 560 AUGUST 27,2010 H 208, BACIMORE, M)							
,			20 No===	CO NO F			- 00-1 /T	Date ()		00000	560	MUCHUS	T 2+	100	10	
			30. Name and add	AT ICI	to completed caus	or death (Iter	06.01	+ILA1	DELT	THA RD	村 20%	RAM	IM MI	E.Mi)	
	Stat	e	31. Date filed (Moi			egistrar's Signa	ature /		,			, ,,,,	4 .OI.	1	<u></u>	
	Stat	_		IIC 21	2010		M And	2 Kel	7							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DINGLE CHARLES 1125 AM August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore North WEST HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year, No. Carolina 1 🖳 M 2 🗆 F Director Aug 30, 1932 240-44-0093 Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Windsor Mills Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 U.S.A. 5505 Northgreen Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1953 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 1954 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ft .George Meade Motor **Bus Driver** 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Theola Riley Dingle Irvin Dingle Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5505 Northgreen Road Windsor Mill, Maryland 21244 Pamela Dingle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 09/07/10 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of Funeral Servi 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sepsis Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Examine tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 1 | Yes 2 | g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomiposathy 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. • Funeral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 ETNO မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physician:

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Kafrouni

Louin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Abdallah

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D65843

5401 Old Court Road, Randallstown, HD 21133

August, 27, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Richard Delouise	1- For State Registrar		ertificate of		Mental Hygi	ene Reg	. No. 2010	2724			
Physician Medical Examine		DeLouis	se		N	Date of Death Month [Jugust 25, 2	Day Year	3. Time of Death 1800 hrs			
	4a. Facility Name (if not institution, given Suburban Hospital			b. City, Town, or Loca Bethesda		.ugust <u>2</u> 0, 1	4c. County of Deat	h			
Funeral Director	5. Social Security Number 6. S 059-26-9677 1	7. Age (In yrs.	. last birthday) Yrs.		Hours Min.	Date of Birth	(MM/DD/YYYY) 9. Bi Forei	irthplace (State or ign ^{ountry)} New York			
w any	Usual Residence of Decedent 10a. State 10b. County MD Mont 9	10a. State 10b. County 10c. City				10d. Inside City Limit					
the Maryland a or 28a-f show any liffed at once.	10e. Street and Number	omery		Bethesda 10f. Zip Code		10g	. Citizen of What Cou	1 Yes 2 X No			
3a or 23 otified		1.		2081	7		United St	ates			
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Firneral Director	3 Midowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year	If Ye	Decedent of Hispani is, specify Cuban, Me Yes 2 X No sp	xican, Puerto Rica						
nours aff	6 45 5 - 1 - 1 - 5 - 5 - 5	or Dates: nly, highest grade completed)	16a. Decedent	s Usual Occupation (st of working life, DO	Give kind of work	done 1	one 16b. Kind of Business/Industry				
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4 or 5+) 5+		conomist		at Middle Me	Finance				
215- be filed ntal Hyg rrked oth	Louis	DeLouise		18.M	Marg		Alfier	i			
ID 21 should and Me and Me 77 is ma natic ev	19a. Informant's Name/Relationship (1 Barbara DeLouis	· · · · ·	100	Address (Street and Stoneham)			er, City or Town, State				
re, M l and 2 Health fitem 2	20a. Method of Disposition	20b.		ion (Name of cemeter	ry, Da	te 2	20c. Location - City or				
Eimol Pages ment of tant: I	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify	Ch	esapeake	Cremator	у	/2010	Beltsvil	le, MD			
Physician injury	21. Signature of Funerel Service Licer	MOOS	1933	eme and Address of F p Funeral B Gist Ave	Silve	r Sprii	no MD 2	2090 Approximate Interval			
/Medical Examiner	failure. List only one cause on ea	ich line. Hypertensive Atheroso Due to (or as a consequence	clerotic Cardio					Between Onset and Death			
	Sequentially list conditions, b.										
0, e be executed sician and burial - transit	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Underlying Cause (c. Due to (or as a consequence of):										
t0, e be executed ysician and burial - transit edical Exe	d.	· · · · · · · · · · · · · · · · · · ·	-								
60, ate be ex hysician e burial		AMENDED 23c. If yes, outcome of pre	gnancy				23d. Date of deliver	<u> </u>			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial - transilical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician/Medical Exilical Certification: To Be Completed by Physician/Medical Exilication of the completed by Physician/Medical Exilication of the completed by Physician/Medical Exilication of the completed by Physician of the compl	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)										
, P.O. Bc res that the des signed by the a be detached fr d by Phys		contributing to death but not	resulting in the un	derlying cause given	in Part I.		2 No 3 Prol	the cause of death?			
Division of Vital Records, na or Attending Physician: The law requires rs after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be ertification: To Be Completed		· · · · · · · · · · · · · · · · · · ·				24a. Was an autopsy performe	prior to one death?	utopsy findings available completion of cause of			
tal Recidian: The certificate rector, page	25. Was case referred to medical				eath (Check only o	one)	No 1 ✓ Ye	es 2 No			
of Vit ling Physic After this c funeral dire	1 Yes 2 No	lospital: 1 Inpatient 2				lursing Home 5 Residence 6 Other:					
ion C tending leath. tor: Aft the fun	1 Natural 5 Pending 2 V Accident Investigati	Aug 25, 2010	1730 hrs	1 Yes	- Sub		ed in swimming	pool			
Division o spiral or Attending hours after death. nneral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 9600 Fernwood Road, Bethesda,										
		an: To the best of my knowled On the basis of examination									
To vit Con	29b. Signature and title of certifier	and manner stated.		29c. License nun		29d. Date signed (Month, Day, Year)					
	30. Name and address of person who	mb	MB			F	August 26, 2010				
	Melissa Brassell, MD As	ssistant Medical Exami	iner 111 Pe	nn Street, Baltin	nore, MD 212	01					
State Registra		32 Registrar's Signat	1. box	4							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Jarrett Dymczenski 01330 PM uly 21 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Juli 21 . 2010 212+89-4520 Mary land Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4213 Kensington Road 21229 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withinthent of Health and Mental Hygiene reant: If item 27 is marked other the njury or other traumatic event, the N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mark Matthew Dymczenski Kirsten Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Kirsten Dymczenski - Mother 4213 Kensington Rd., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 8-28-2010 Brooklyn Park, MD 4 Donation 5 Other (Specify) Sign tur-Fun ral Service Lice 2. Name and Address of Facility Am rose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOVASCULAR disease or condition Medical resulting in death) **Examiner** EXTREME PREMATURIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕍 No 3 🗋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe Yes 2 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0027352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSEER DRIVE TOWSON m.D. MARYLAND 21204 BENNET

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signat

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 27250 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1,04 Physician/ Avaust 2016 7:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WICKLOW altimore 5. Social Security Number 217-64-7386 Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 D M 2 DF Months Days Hours Min. (Month, Day, Director Usual Residence of Decedent 28a-f show 10a State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Ses 2 No 10e. Street and Number 10f Zin Code P 10g. Citizen of What Country? Funeral 23ahours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 Married 'natural", or þ 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 2230 (Department of Health a Important: If item 27 is any injury or other tra Williams Heland Timner 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12010 21. Si way re of Funeral Service Licenses 22. Name and Address of Facility Home 1Q 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe this certificate 2 **N**No Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

21215-0036

Baltimore, Maryland

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

600

Zheng

31. Date filed (Month, Day, Year)

D64552

WOLFE ST. Baltimore, MD21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 4:36 <u>Marie Carmel</u> Exantus Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Days Hours Haiti 3/30/1958 Director 52 053-58-8526 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Somerset Somerville 1XXYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 08876 USA 6 Demond Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter Black White etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Computer Analys yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Andrea Depas Innocent Exantus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Somerville, New Jersey Demond Place Exantus/Brother Karl Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) 8/28/2010 | Alexandria, Virginia Metropolitan Crem. 22. Name and Address of Facility Marshall March Funeral Home 21. Signature of Funeral Service Licenses 4217 Ninth Street, NW Washington, DC lean 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 wKs PSELOOMONA Physician/ tNEUMONIE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner LOMPKOBLASTIC SB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine pue to for as a consequence of, requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ned by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c BLERDING 2 No 3 Probably 4 Unknown Records, CORGULOPATHY ABBOMINAL 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FUNCIEMA ENCEPHAWMENTS Hospital or Attending Physician: The law page 2 certificate has autopsy performed?
1 Ves 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this s after death.

Il Director: After this id in by the funeral di 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I To the Hospital of within 24 hours a To the Funeral D completed filled is Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 25 2 MA 233900 PRASAG

Registrar

DHMH 17 Rev 7/2009

State

10 Center Drive, Bethesda, MD 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERUTUSH

31. Date filed (Month, Day, Year)

AUG

PRAJAO

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:50 AM Medical 4a Facility Name (if not institution, give street and number, Examiner County of Death If Under 1 Year | If Under 5. Social Security Number g. Birthplace (State or Foreign Age (In yrs. 24 Hrs. 8. Date of Birth **Funeral** Months 1 □ M 2 🖭 Days Hours Min. (Month, Day, Director Usual Residence of Decedent or 28a-f show notified at 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No more 10e. Street and Number ò 10f. Zip Code 10q. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in Funeral 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 ₩Widowed 4 □ Divorced lac Year or Dates 15. Decedent's Education Decedent's Usual Occupation
 (Give kind of work done during most of working life. PQ NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) conday (0-12) Elementary/Se College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ister 20a. Method of Disposition 20h Place of Disposition Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Now disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO Other: 1 Tes ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of icense numbe 29d. Date signed (Month 2010 Name and address of son who comp led cause of dea h (Item 23a) (Type, Print) Registrar's Signa State

DHMH 17 Rev 7/2009

Registrar

	-	For State Registrar		State of Ma	ii yiaiiu /		tificate of E		a Mentarriy	Reg. N		21200
Physician	1/	1. Decedent's Name (Fi	- 1 .		1/200	لما			2. Date of D	Г	Day Year	3. Time of Death 4:00 P M
Medica Examine	al	4a. Facility Name (if not	institution, give		Vere	17	4b. City, Town, or	Location of D	Hugust		7 2010 Ic. County of Death	•
	-1	Washing	g for C	ounty	Hospit		Hag	ers to	nu		Wash	nington
Funeral Director		5. Social Security Number 214-03-53 Usual Residence of Dec	94	XM 2 GF	(In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D OCt • 2	rth ay Year 4	9. Birth 917 Mar	place (State or Foreign ntry 1 and
land show d at	ţo	10a. State 10	b. County		10c. City, Tow							10d. Inside City Limits
th the Maryland 3a or 28a-f shov t be notified at	Sirec	MD 10e. Street and Number		ngton		наде	10f. Zip Code	_		10.0		1 Yes 2X No
with th	Funeral Director	448 Fair		ws Blvd			21740)		10g. C	Citizen of What Cou	ntry ?
fter o	<u>م</u>	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		12. Was Decedent Ev Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No		? (Specify Yes or No uerto Rican, etc.)	-	14. Race - Ameri Black, White, Specify: Whi	etc.
2 hours	plete	15	5. Decedent's Ec only highest gra	fucation	16a	. Decede (Give k	ent's Usual Occup	ation during most of	working	16b.	Kind of Business In	dustry
vithin 7, iene.	Completed	Elementary/Seconda		College (1-4 or 5-	Ro	life. DC	NOT use retired)	_	_	Ro	ofing C	ompany
should be filed within 72 hou and Mental Hygiene. is marked other than "natu aumatic event, the Medical	a)	17. Father's Name (First							Name (First, Middle		n Surname)	
d Ment marke matic	ř	Robert 19a. Informant's Name			101	. Maille	n Address (Charach		e Carte		or Town, State, Zip	Codel 21740
1 and 2 should be of Health and Men item 27 is marke other traumatic		Rodney E	verett		4 4	18 E	Tair Mea		Blvd. H	age	rstown,	Maryland
Page nent c ant: If ury or		20a. Method of Disposit 1 XBurial 2 C 4 Donation 5	Cremation 3	Removal from State	Morelar	nd Me	ition (Name of atory or other plac TOTIAL Part		t.1,2010	Par	kville, Ma	aryland
permit. Departi Import any inj		21. Signature of Funera	Service License	7º Fadde		22. 88	Name and Address Ans. Fune Harfo	ss of Facility ral Cha ord Road	pel and Parkvil	Cren	mation Semaryland	ryises 21234
Physician/ Medical	0	23a, Part 1. Enter the c	lisease, or comp ilure. List only or		mona	not enter						Approximate Interval Between Onset and Death
Examiner		Sequentially list condit	ions	b ————————————————————————————————————	consequence	01).						
uted Id ansit	Examiner	Sequentially list condit if any, leading to imme- cause. Enter Underlyin Cause (Disease or iinju that initiated events	diate g ry	Due to (or as a	consequence	of):						
ificate be executed g physician and as the burial-transit	Medical Ex	resulting in death) Last	L	Due to (or as a	consequence	of):						
ath cert attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal deat		Ectopic pregnance Other (specify)	су			23d. Date of deliv	very Day Year
requires that the de been signed by the s should be detached	by P	Part II. Other significar	nt conditions co	entributing to death bu	it not resulting	in the ur	nderlying cause giv	ven in Part I.			use contribute to t	
equires een sig	eted											obably 4 Unknown
he law r tte has b	Completed	Years of a							— 24a. Wa: auto per 1 □ Yes	opsy form ę d?	prior to co death?	opsy findings available ompletion of cause of
ician: T	Be	25. Was case referred to examiner?	l-	Hospital:					Check only one)			
y Physi er this c eral dir	e: 10	1 Yes 2 XV	0	1 Ninpatie 28a. Date of injury		Time of	28c. Injury	4	ng Home 5 Res		6 Other (Specificary occurred	y)
ending eath. or: Afte the fun	Certificate:	2 Accident	☐ Pending Investigation ☐ Could not be		Year)	injury	M 1 🗆	? Yes 2 \sum No				
tal or Att rs after d al Direct ed in by t		4 Homicide	determined	28e. Place of Injur building, etc.		arm, stre	et, factory, office		28f. Location City or To		and Number or Rura te)	d Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to completed filled in by the funeral director, page 2.	Medical	(Check 2 U only one) 3 U	Medical Examir Certifying Nurs	ician: To the best of n ner: On the basis of ex e Practioner: To the b	amination and/	or investi	gation, in my opinio	on, death occur	red at the time, date	and place	ce, and due to the ca	ause(s) and manner state
Vith vith con		29b. Signature and title	of certifier	,,,	MD		29c. License	number 0 689	76	29d. [Date signed (Month,	30 2010
ny√		30. Name and address	of person who co	ompleted cause of de 3 e yene	ath (Item 23a)	(Type, Pr	int)	Coi) N ty H	105	p. Falte	gerstainy mo zity
State		31. Date filed (Month, D.	ay, Year)	32. Red 5	's Signature	-					, , , , , , , , , , , , , , , , , , , ,	
Registra		AC.	0120	110 Please	a pl.	1	B. Kall					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Pay} 2010 ear Moreth 08h **Physician** 3:31А м Mary Diane Frilot /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7829 Statesman Street Severn Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Michigan 8. Date of Birth (Month, Day, Year) 07-21-1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 1 F Months **Director** 562-62-6922 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a United States 7829 Statesman Street 21144 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo Specify: þ Specify: 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1*4or 5+) Dept. of Defense Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McIllroy William Metivier မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trauging. 7829 Statesman St., Severn, Maryland 21144 Raphael A. Frilot- spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 KX remation 3 ☐ Removal from State 08-20-2010 | Glen Burnie, MD Atlantic Crematory 4 ☐ Donafton 5 ☐ Other (Specify) 21. Signatur Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final an ce Variou Physician INR 400 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its land. Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 Yes 2 No n signed by tf Id be detach€ g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Eccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 the death certificate be Division of Vital Records, or Attending Physician:

72 hours after

Pages 1

Baltimore, Maryland 21215-0036

State

30. Name and add person who completed cause of death (tem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Clement B. Knight, M.D., 10710 Charter Drive, Suite GO20, Columbia, MD 21044 31. Date filed (Month, Da 32. Regis

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30PM Augus Year **Physician** nreen Hudrei 25 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6119 Oakland Mills Road Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Aug 18, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days ^Y1916 Months Hours 1 □ M 2 □XF 94Yrs 212-42-7675 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event; If a Medical Exercity in all respectived at any pince. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21045 6119 Oakland Mills Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2No Specify: δ Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Unk. Edward E. Green ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2133 Cedar Circle Drive Catonsville, MD 21228 Edward Day, Personal Representative 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/26/10 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licens & Thomas Gregor Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hilheroselere **Physician** "ardiovascyar ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UDEIT ENSIG Equaritiany flot or differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of) Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 I Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2 🕱 No certificate 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TR Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amoton Macon MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOLPHIN State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 26 ay 20 1°0 8:15 P M LILLIAN GERSTEIN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE PIKESVILLE MILFORD MANOR NURSING HOME If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Days Hours 0872777922 216-16-1799 88 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 💢 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY BEINER FLORENCE SCHREIBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TROTTERS COURT, APT. T-3, BALTIMORE, MD 21208 JUDY FLAX-GERSTEIN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State RODFE ZEDEK CEMETERY 08/29/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) al nature of Funeral Sept. License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a, Dan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final nd Stage ementio disease or condition resulting in death) ear) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If ye 23b. Was decedent pregrant in the past 12 modiths?
1 ☐ Yes 2 ☑ No

Physician Medical Examiner

attending physician and for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a

To the Funeral Director: After this certificate has been signed by the a

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

Completed by

Be

은

Certificate:

Department of Important: If it any injury or o once.

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

6

er than "natural", or items 23a of the Medical Examiner must be

al Hygiene.

t. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If item 27 is marked other ' njury or other traumatic event, th

Director

Funeral

Completed by

Be

မ

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

IF FEMALE:

s, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death	3 Ectopic pregnan 5 Other (specify)
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23d. Date of delivery CV Day

24a, Was an

1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9

3e. Did tobac	co use con	tribute to the cau	se of death?
1 🗆 Yes	2 D No	3 Probably	4 🗌 Unknown

Year

24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify

27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation □ Accident
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

			For State	State of Marylan				Mental Hy		10	27257		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	Death	2. Date of De		10	27257		
	Physicia Medic		ROSE M		NSBURG			Month AUGUS'		20 ^{Ya} ar	3. Time of Death 4:26 PM		
	Examin		4a. Facility Name (if not institution, give st	,		4b. City, Town, or		th	4c. County of Death				
			GILCHRIST HOSPIC 5. Social Security Number 6. Sex		ot hirthday)	TOWSON If Under 1 Year	If Under 24 Hr	o Data of Bio	BALT		lana (Chahana Familian		
	Funeral Director			м 2 ДF 94	Yrs.	Months Days	Hours Mir			9. Birtinp Count	lace (State or Foreign ry) MD		
	d ow t	L	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	nation				14	Od. Inside City Limits		
	arylan ia-f sh ified a	Director	MD BALTIMOI		VINGS 1						1 Yes 2X No		
	the M or 28		10e. Street and Number	AL O	VIIIOD I	10f. Zip Code			10g. Citizen of	What Coun	try?		
	h with 1s 23a nust k	Funeral	3420 ASSOCIATED V	WAY, #410		2111	7		Į	JSA			
	r deat or iten niner r	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No	i. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (5 n, Mexican, Pue	Specify Yes or No- to Rican, etc.)		ce - America ck, White, e			
93	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔀 No	Specify:		Specify	WH]	ITE		
5-0	72 hou "natu edical	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	dent's Usual Occupa kind of work done o		orking	16b. Kind of B	usiness Ind	lustry		
72	ithin itene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) ${f IMS}$ ${f EXAMI}$	NER		SOCIAL	SECUI	RITY		
b	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surnam				
yla	uld be I Ment narke	မ	HARRY	MATZ			SARAH				SIEGEL		
Ma	12 should lith and Me 27 is marl		19a. Informant's Name/Relationship (Type SAREVA RACHER/DAI			ng Address (Street a 4 CENTURY			-				
Je,	1 and of Hea item other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location				
<u>im</u>	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State BE'	rnetery, crem	natory or other plac MEMORIAL	PK 08/	30/2010	RAND	ALLST	OWN, MD		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	146		. Name and Addres							
	2010		23a. Part 1. Enter the disease, or compli	cations that caused the death		900 REIST				LE, MI	21208 Approximate		
20	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition			,				Δ	Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequ		Ciclo	CC; V			-	1902+ 9010		
	Laminor	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence off:								
	nted d ansit	Examiner	Cause (Disease or linjury		ondo oij.								
	ate be executed hysician and the burial-transit	EX.	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):								
200	ate be	edical	d	l									
89	certific nding use as	M/m	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnal		1			23d. Da	ate of delive	ry		
Box 687	requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 2 No	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Ectopic pregnanc Other (specify)	у		Mo	onth	Day Year		
P.O.	at the d by th		9 Unknown Part II. Other significant conditions con	<u> </u>	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?		
<u>s</u> ,	ires th signe Id be o	Completed by	apatic sknosis,	Ottial Film	liates	, huper	tersion	1 🗆	Yes 2 No	3 Prob	ably 4 🗆 Unknown		
oro	w require been so shou	plete				9.		24a. Was			sy findings available		
Be	The la	Com						perfo		death?			
Ita	sician: certific rector,	Be o	25. Was case referred to medical examiner?	ospital:		Othe	ace of Death (Ch		26		1100000		
of V	g Physer this leral di	e: To	27. Manner of Death		28b. Time of	28c. Injury	at	Home 5 Resid	dence 6.000 Oth ow injury occurr		HODGE		
on	eath. or: Aft	ficat	Natural 5 ☐ Pending Accident Investigation Gould not be	(Month, Day, Year)	injury	M 1 □	/ Yes 2□No						
Division of Vital Records,	or Att after d Direct in by 1	Certificate:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow	street and Numb n, State)	er or Rural	Route Number,		
Ω	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical		ian: To the best of my knowle									
	the Ho nin 24 the Fu	Med	only one) 32 Certifying Nurse	er: On the basis of examination Practioner: To the best of my									
	o P with		29b. Signature and title of certifier	50.0		29c. License			29d. Date signe	d (Month, E	Pay, Year)		
			39 Name and address of person who cor	mpleted cause of death (Item	23a) (Type. P		5356		Mode	2 3	0 9010		
			Kelsecco Sutal		347	10WSON	E nuo	Bud To	Suson	MO	21304		
	Stat Registra		31. Date filed (Month, Day, Year) AUG 3 1 2010	32. Registrar's Signat	par par	Kal							

			For	State of	Maryland					and M	ental Hy	giene				
		_1	State Registrar			Cer	Certificate of Death						Reg. No. 20 0 27258			
	Physicia		1. Decedent's Name (First, Middle, L	.ast)	610	GER					2. Date of Dea		20 ⁴ 10	3. Time of Death 3:00 A M		
	Medic	al -	4a. Facility Name (if not institution, g	ive etmet and numb		600	4b. City, To	wn orl	ocation o	f Death	1100001		County of Death			
	Examin	er '	8109 AN		<i>(</i>			TIMO						TIMORE		
-	Funeral			. Sex 7	7. Age (In yrs. la	st birthday)	If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birth			hplace (State or Foreign		
	Director		213-80-6585	1 □ M 2 🔀 F	89	Yrs.	MOILING	Days	Tiodis	IVIII I.	06/217	0672171921 Country POLAND				
	d t ow	. 1	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Loc	ation							10d. Inside City Limits		
	a-f sh	Director		IMORE		SALTIMO								1 ☐ Yes 2X☐ No		
	or 28	ä	10e. Street and Number	HORE			10f. Zip C	Code				10g. Citiz	en of What Co	untry?		
	with t	Funeral	8109 ANITA ROAL)			1	2120					USA			
	items er m	딆	11. Marital Status	12. Was Deced	dent Ever in U.S	5. 13. V	Vas Deceder f Yes, specify	nt of Hisp y Cuban,	panic Orig , Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 			
9	after c	ρ	1 ☐ Never Married 2 🙀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Tyes If Yes, Give	2 X No	1	☐ Yes 2	X No	Specify:			s	specify:	WHITE		
215-0036	atura cal Ex	Completed	15. Decedent	Year or Dat s Education	tes.	16a. Deced	lent's Usual (Occupat	tion			16b. Kir	nd of Business	industry		
Ċ C	. 72 h	ם	(Specify only highest Elementary/Seconday (0-12)		4 or 5+)		kind of work O NOT use re		ıring most	of workir	ng					
717	filed within 72 hours after death with the Maryland of the Wigner and at Hygiene death with the West sho went, the Medical Examiner must be notified at went, the Medical Examiner must be notified at	ပ္ပို	12			HOM	EMAKER						HOME			
n	is filed within 72 hours after death with the Maryland tal Hyglene. An experience of the first state of the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, La.					l	18. Mothe		(First, Middle,	Maiden S		AXLER		
<u>≥</u>	ld be Men arke		MOSHE 19a. Informant's Name/Relationship		USHMAN	10h Mailie	as Address /	Street or		_	Route Numbe	er City or 1	Town, State, Zip			
Ma	2 shou Ith and 27 is m r traum		SAMUEL GLOGER								TIMORE		21208			
<u>6</u>	and Hea em em		20a. Method of Disposition			Place of Dispo emetery, crer	sition (Name	e of			Date	20c. Lo	cation - City or			
Ë	e = ; e		1 X Burial 2 Cremation 3	∃ LI Removal from ecify)		H TFIL					0/2010		BALTIMO			
Baltimore, Maryland 21	permit. Pag Department Important: any injury once.	1	21. Signature of Juneral Service Lic	ensee			2. Name and							., INC.		
<u> </u>	9 9 E 18 9	_\	Jatiely	1 - Ylan									SVILLE,	MD 21208 Approximate		
			23a. Part 1. Enter the disease, or shock, or heart failure. List on	emplications that d ly one cause on ear	aused the deat ch line.	h. Do not ent	er the mode	or aying	-		-	11031,		Interval Between Onset and Death		
- 4	Pnysician Medical		Immediate Cause (Final disease or condition resulting in death)	a	112	HFT	ME	25	DI	-MA	NT.	CA		LYRS		
	Examiner			Due to (or as A consequ	Sac A	el	AR.	TER	15	DIS	E45	E_	30 YRS		
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	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	c	DJA	BET	ES	<u> </u>	167	LI	-Tu	<u> </u>		90 (K)		
	te be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):										
90	ate be physic the b	edical		d												
687	eath certificate attending phy I for use as the	Ž	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, out	come of pregna	ancy	7 5 -4					1	23d. Date of de	elivery		
Box 687	eath c atter	icia	in the past 12 months? 1 ☐ Yes 2 No		Birth 2 Feta		☐ Ectopic pi ☐ Other (spe		y 				Month	Day Year		
В	the d by the	Physician/Med	g 🗌 Unknown			culting in the	underlying o	auee div	on in Part	1	23e Did	tobacco u	se contribute to	o the cause of death?		
P.0.	requires that the der been signed by the s should be detached	þ	Part II. Other significant condition	is contributing to a	eath but not res	suiting in the	underlying G	ause givi	en in r art	. 1.				Probably 4 Unknown		
rds	equire een si nould	Completed									24a. Wa	s an		utopsy findings available		
900	law r has b je 2 sl	mpl									aute _ per	opsy formed?	death?	completion of cause of		
H.	siclan: The law is certificate has be lirector, page 2 s		25. Was case referred to medical					26. Pla	ace of Dea	ath (Chec	l 1 ☐ Yes k only one)	2 No	ој тште	s Z 🗀 NO		
Vita	/sicla s certi directo	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatie	ent 3 🗆 DO	Othe	er: 4 🗆 N	lursing Ho	ome 5 Res	idence 6	Other (Spe	cify)		
of	ng Phy ter thi neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	of 28	Bc. Injury work	?	- 1	28d. Describe	how injury	y occurred			
on	tendir leath. or: Af the fu	ifica	2 Accident Investig	ation	- A - E		M factors		Yes 2	□ No	29f Location	(Street and	d Number or Ri	ural Route Number,		
Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide determi	28e. Place	e of Injury - At h ing, etc. (Specif	ome, farm, st	reet, factory,	, once		- 1	City or To	wn, State)	arar route rearros,		
	To the Hospital or Attending Physiclan: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director,			Physician: To the b	est of my knov	vledge, death	occured at	the time	, date and	place, ar	nd due to the d	cause(s) ar	and due to the	tated.		
	n 24 h	Medical	only one) 3 Certifying	xaminer: On the bas Nurse Practioner:	sis of examination To the best of n	on and/or inve ny knowledge,	stigation, in r death occur	red at the	e time, dat	te and pla	ce, and due to	tne cause(s	s) and manner a			
	Vithi To the		29b. Signature and title of certifier	/			290.		number			29d. Da	te signed <i>(Mon</i> RISG	tn, Day, Year)		
			Mound	w m	>	- 00 \ =	Dula ()	00	175	(-)	0		17	110		
			30. Name and address of person	The completed cause	se of death (Iter	m 23a) (Type,	ARRY	LA	15E)r.	BAC	TIV	rore 1	ND21209		
	Sta	ite	31. Date filed (Month, Day, Year)	40 \$2.F	Registrar's Sign	ture	Mad	,(
			ALIC Q 1 21	ALLE THINK	Market 10											

DHMH 17 Rev 7/2009

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOSTAW 2010 4:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SIMM BALTIMORE BALTIMORE HOSPITAL OF Social Security Number 6. Sex **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 🕟 (Month, Pay, 214-40-069 Months Min **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland antment of Health and Mental Hygiene. Nortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MI 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral the 4103 elle Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed d 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life, DO NOT use retired) ry/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other ဂ 11a 19a, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) onstantina Parient 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State TIVISON 4 ☐ Donation 5 ☐ Other (Specify) Forest 21. Signature of Funeral Service Licenses 2a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a drdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death to (or s a consequence of): disease or condition Medical resulting in death) Due to (or **Examiner** Neuhepenia Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Breast metastanc Cancer that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Records, P.O. ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Covenary areny disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive heart certificate has autopsy **Division of Vital** 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) Wina MBBS Kopnawiesy RES -000 August 29 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS SINA ROOPNARINESIN 4 HOSPITAL CF BALTIMORE State Registrar's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Raven iving DMMUNITY **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **½** M 2 □ F (Month, Day, Year) 8-1-1939 Director 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director MDBaltimore Pikesville 1 Tes 2 X No 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Al-Hannah Circle 21208 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give African-American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Constructor Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James H. Holt II Irene Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley I. Holt/Wife 9 Al-Hannah Circle, Pikesville, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Veterans : 4 Donation 5 Other (Specify) 9=8=2010 Owings Mills, MD Wylie Funeral Home P.A. of Balto. Co. Sign re of Funeral Service Licensee 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine If any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No မ 1 🗙 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29c. License number

104

Registrar
DHMH 17 Rev 7/2009

State

ted cause of death (Item 23a) (Type, Print)

3900

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Doris Jean Hollandsworth 23:42 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Co. Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X Days Hours West Virginia 78 235-46-2989 **Director** 1932 Usual Residence of Decedent 10a State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director : If item 27 is marked other than "natural", or items 23a or 28a-fs or other traumatic event, the Medical Examiner must be notified Maryland Harford County Jarrettsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3905 W. Bend Drive 21084 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 12 Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filec Department of Health and Mental Hy Important: If item 27 is marked otf any injury or other traumatic eveni 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harlan Ware Mary Cowger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hollandsworth (son) 2421 Munford Drive, Fallston, Maryland 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 30, 2010 Fallston, Maryland Highview Memorial 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services - BelAi 3 Newport Drive, Forest Hill, Maryland 21050 edm A Newport Drive, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhadic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** hours Breedin ectal Sequentially list conditions, Examiner it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò oagulopathy 1 Yes 2 No 3 Probably 4 Unknown Completed aortic stenosis 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy kidney disease certificate | chronic 1 🗆 Yes 2 🗆 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ᅆ After this o 1

■ Inpatient 2

■ ER/Outpatient 3

■ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di completed filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August, 27, 2010 D006542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLIEM GENERAL AND 500 Upper Chesapeake Drive, Bel Hir, MD 21014 MD State AUG 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Hollandsworth

			For	State of Ma	aryland /	•			and M	ental Hy	giene	010	27262
			State Registrar	0		Cer	tificate of L	Death				010	27262
Phys	ician edica		1. Decedent's Name (First, Middle, Last	<i>t</i>)			HIL	_		2. Date of De Month	Day	6 2010	3. Time of Death 9 4:21 P M
	mine		4a. Facility Name (if not institution, give s	street and number)	AL		4b. City, Town, or	r Location		J	4c. Ce	ounty of Dea	th
Fune Direct			5. Social Security Number 6. Se.		(In yrs, last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	y, Year)	Co	rthplace (State or Foreign ountry)
	_	İ	Usual Residence of Decedent							<u> </u>	3 41		
yland -f sho		횽	10a. State 10b. County		10c. City, Tov								10d. Inside City Limits
e Mar r 28a		훒	MD NA 10e, Street and Number			Bro	oklyn 10f. Zip Code				10- Citizo	en of What Co	1 XYes 2 No
vith th		<u>a</u>						21229	c				
eath v tems		Funeral Director	227 Bishop Ave	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H	ispanic Ori	igin? (Spec	ify Yes or No-		. Race - Ame	erican Indian,
DEBILIMOFE, IMBRYIGHO Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any initur or other traumatic event. the Medical Examiner must be notified at		۾	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		Yes, specify Cuba			lican, etc.)	Sp	Black, Whit	·
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Yiand Jid be filed Mental Hy narked oth		9	Jasper Johnson						ice		ivialueri Sul	riarrie)	
ary hould ind Ma s mar		1	19a. Informant's Name/Relationship (Typ	pe, Print)	19	b. Mailin	g Address (Street a				r, City or To	wn, State, Zi	ip Code)
, Mal id 2 shou salth and n 27 is n er traum			Lloyd HIll-Hush	oand	22	2 7 E	Bishop A	Ave,	Ero	oklyn,	Md	21225	5
OTE TOTE Titer		- [20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐	Removal from State	20b. Place cemet	of Dispos	sition (Name of natory or other plac			ate	20c. Loca	ition - City or	r Town, State
baltimore , Dermit. Page 1 and Department of Hes mportant. If item any injury or othe		1	4 Donation 5 Other (Specify)	Oı	n-Si				/2010	Bal	timo:	re, Md
Departing Department of the pool of the po	ouce		21. Signatura a Funeral Service License	Anon?	+	Ma 43	Name and Address Name and Name and	s of Facilit I Wes ash	st Ave,	Balti	imore	, Md	21215
			23a. Part 1. Enter the disease, or compositions shock, or heart failure. List only on										Approximate Interval Between
Ph sicia	_	4	Immediate Cause (Final disease or condition	Chronic	obst	ruct	tive Pu	lno	mary	Lis	ease	:	Onset and Death
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r ov ate be executed physician and the burial-transit		edical Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						·	
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The Hospital or Attending Physician: The law requires that the death certification in 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	M/ Wolci	~ I	in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal dea		Ectopic pregnanc Other (specify)	;y			230	d. Date of de Month	elivery Day Year
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or Attendir s after death. I Director: Af d in by the fu	1		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		arm, stre	et, factory, office		2	8f. Location (S City or Tow		umber or Ru	ral Route Number,
e Hospitz n 24 hours e Funera	Andina	Medical	29a. Certifier 1 Certifying Physi (Check 2 Medical Examin only one) 3 Certifying Nurse	i er: On the basis of ex	amination and/	or investi	gation, in my opinio	on, death oo	ccurred at t	he time, date a	nd place, an	nd due to the	cause(s) and manner stated.
To the				margency	Depan	men	29c. License		110			signed (Monti	
			30. Name and address of person who co	empleted cause of de	ath (Item 23a)	(Type. Pr	rint)	76	060	7	augi	IST A	-1,2010
			Date Barnes M 31, Date filed (Month, Day, Year)	ND 30			MOVER	St	Bal	timer	e, 1	Mari	yland
Regi	State strar		AUG 3 1 2010	A Registrar	a Signature	par	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cer	tificate of	Death		Reg. No	2010	27263
0	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Dea	ath Da	v Year	3. Time of Death
	/Medic		CHARLOTTE ROSA					AUGUST			1:10 A M
j	Examin	er	4a. Facility Name (If not institution, given the context of the co	ve street and number) KE MEDICAL CENI	מישו		r Location of Death	1	4c. County of Death HARFORD		
1.50	Funeral			Sex 7. Age (In yrs. la		BEL AIF	9. Birthi	place (State or Foreign			
	Director		213-28-4351	1□M 2 X F 79	Yrs.	Months Days	Hours Min.	Jan. 2	$1, \frac{\text{rear}}{1}$	931 Mary	land
	w w		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	eation					10d. Inside City Limits
	Aaryla f sho	ō									1 □ Yes 2X No
	r 28a-	Director	Maryland Baltimo 10e. Street and Number	re Pa	rkvil]	10f. Zip Code		1	10g. Cit	tizen of What Cou	ntry?
	h with		1814 Forrest Ro	ad		21234			US.	A	
	ems (Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Vas Decedent of H	lispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,	
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the five fical Ever death in the five filed.	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2▼ No If Yes, Give Year or Dates:		□Yes 2□No	Specify:			Specific	ite
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<u> </u>	d 2 should be f th and Mental 7 Is marked or traumatic eve	오	Alexander Theopo		10h Mailin	a Address (Street	and Number or Ru				n Code)
Baltimore, Maryland 21215-0036	d 2 s		Coletta Springer				Jarrett				2 0000)
re,	es 1 and 2 of Health item 27		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of natory or other place	e) 9-2	_DateO	20c. Lo	ocation - City or To	own, State
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3alt	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	nsee	ŽŽ Mc	Name and Addre	ss of Facility Ineral Ho	me, P.A			
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> ·	iding Physician: th. After this certifical funeral director, p		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 ☐ DOA Oth	er: 4 🗆 Nursing H	ome 5 Resi	dence	6 ☐ Other (Speci	ify)
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120	ttend death stor; / the f	icat	2 Accident investigation 3 Suicide 6 Could not be		me farm stre		Yes 2 □No	28f Location /	Stroot	nd Number or Rur	n I Poute Number
Division of	lor A after Direct d in by	Certification: To	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify))	oet, lactory, office		City or To	vn, State	e)	ar rioute Number,
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,	5 w t	Σ	29b. Signature and title of certifier	1 - hand	al.nl	29c. Licens	e number	7	29d. Da	ate signed (Month,	
			20 Name and address	- 105/MT	2005	Durint)	0 00 (140	19451	28,2010 Am 21014
			30. Name and address of person who	completed cause of death (Item	∠3a) (Type, F	Masaur.	ca dec	An	Br	JAIN	un 21015
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure	- Topo		V 1	1/6	7 7 1 7	
	Registr	ar	AUG 3 1 2010	Dennet D.	back	7					

DHMH 17 Rev 1/2001

Hannon, Charlotte M800472910 8/28/10 0110A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 10:00 AM **JEANNINE** BERTHE HITE 2010 AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITIZENS CARE CENTER HAVRE DE GRACE HARFORD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Hours June 14, 1924 Country) Director 205-26-0736 87 France Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Tes 2 No Maryland Harford Bel Air 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o 23a Funeral filed within 72 hours after death with al Hygiene. 720 Beretta Way 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced White Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) မ Farnand (unk) Gasselin Jeanne (unk) Godarad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark S. Hite / Son 720 Beretta Way, Bel Air, Maryland, 21015 Department of Heall Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn: 8/31/201d Fallston, Maryland Signature of Juneral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Disease Physician oronam Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director; After this certificate | 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 L Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practioner To the best of my knowledge, death promoted at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number D32 G09 8/27 Wham MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arredelraum 21078 Milham Ms Kamman 1100 evalution st

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 19. Physician/ 2010 ea 11:38 A M Margaret Joan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt 413 Baltimore Benson Avenue Baltimore . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 2, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Min. 1937 Maryland Director Aug. 214-66-3379 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗆 Yes 2 🎖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt 413 3300 Benson Avenue 21227 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 3 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white Completed 3 Widowed 4 X Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Caretaker Asst. Health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsworth Leo House Agnes May Marriott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar Darlene Berry / Daughter 1627 Pleasantville Dr. Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, LLCAug. 22, 2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Inature of Everal Service Ambrose Funeral Home Inc. 22. Name and Address of Facility 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Upa pour disease or condition resulting in death) Medical Due t a consequence of: Examiner Sequentially list conditions Examiner if any, leading to immediate
File United States
Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and deed detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown g 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2120 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 2 🗌 No Yes 2 N 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 1063726

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/32. Registrar's Sign

so of an

			for State of Mary		artment of I		and Mental Hy	giene Reg. No. 201	0 27266
	Physicia		1. Decedent's Name (First, Middle, Last) Janet D. Hose				2. Date of De		3. Time of Death
and and	Medic Examir		4a. Facility Name (if not institution, give street and number) 1820 Arbutus Avenue		4b. City, Town, o	r Location o	f Death	4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In 7	yrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 2 Hours			Birthplace (State or Foreign Country) laryland
aryland	a-f show ified at	ector		c. City, Town or Lo	cation Arbutu	.s			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
vith the M	23a or 28 st be noti	Funeral Director	10e. Street and Number 1820 Arbutus Avenue		10f. Zip Code 212			10g. Citizen of What United	Country?
036 s after death v	nt of Health and Mental Hygiene. : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.			ispanic Orig In, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		nerican Indian,
Maryland 21215-0036 2 should be filed within 72 hours after	giene. er than "natul the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a	(Give I	dent's Usual Occup kind of work done o O NOT use retired) Homemaker	during most	of working	16b. Kind of Busines	
Vland of be filed v	Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Phillip E. Johnson, Sr.				r's Name <i>(First, Middle,</i> helma E. Wr		
, Mar, nd 2 shoul	ealth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Robert E. Hose, Jr Son				or Rural Route Number , Arbutus,		Zip Code)
Baltimore , permit. Page 1 and	Department of He Important: If iter any injury or oth	J	1 □ Surial 2 🛛 Cremation 3 □ Removal from State	Ob. Place of Dispos cemetery, crem Atlantic	natory or other plac		Date 8-29-2010	20c. Location - City	
Bait	Depart Import any inj once,		21. Signature of Fun in Service Degree	N 1 22	. Name and Addres	ss of Facility	Ambrose Fu		•
	ysician/	1 9	23a: Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death, Do not ente	er the mode of dying	g, such as c	ardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Medical caminer	<u>۲</u>	resulting in death) Due to (or as a con Sequentially list conditions,	nsequence of):	all	rusc	leron		
ecuted	and -transit	dical Examiner	If any, leading to immodiate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a con	readuante of):					
ate be exe			d						
DIVISION VII.dl RECORDS, F.O. BOX 08/00 THE Hospital of Attending Physician: The law requires that the death certificate be executed to a supervision.	the attending phases the	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of o	lelivery Day Year
S, F.O.	gnec oe de	þ	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.			to the cause of death?
he law requires	ate has been si page 2 should t	Completed	į.				24a. Was a autop	an 24b. Were a prior to death?	utopsy findings available o completion of cause of
ntal r sician: T	ertific sctor,	Be	25. Was case referred to medical examiner? 1 Yes		Otho	r	(Check only one)		es 2 No
nding Phy		Certificate: To	27. Manner of Death 1 ☐ Inpatient 2 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	2 ER/Outpatient 28b. Time of injury	28c. Injury	4 ∐ Nur at		ence 6 Other (Spe	ecify)
LIVISION tal or Attend	ous alter dealt. eral Director. After tilled in by the funera		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe	At home, farm, streecify)	et, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
he Hospii	To the Funeral Completed filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowly one) 3 Certifying Nurse Practioner: To the best of examiners only one)	ation and/or investi	gation, in my opinio	n, death occ	urred at the time, date an	nd place and due to the	cause(s) and manner stated
P	6 00		29b. Signature and title of certifier		29c. License			29d. Date signed (Mon	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	tomin	mel	5 Cerry	Rof =	422)
	State Registra	e r	31. Date filed (Month, Day, Year) 2010 . Registrar's Si	gn dere	led				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death

1. Decedent's Name (First, Middle, Last) Physician/ Year 190 annor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death eal the Kehah HIWaca 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 TA **Funeral** 1 🎛 M 2 🗆 F Months Days Hours Min. 10/14/1923 Director 86 IA 313-12-7531 Usual Residence of Deceden items 23a or 28a-f show er must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Ellicott City 1 Yes 2 X No MD Howard 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21042 United States 2416 McKenzie Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 Ma Yes 2 □ No
If Yes, Give
Year or Dates. 1944–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Equipment Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Sylvia Sergant Verne Hannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2339 Ridge Tree Court Ellicott City, MD 21042 Steve Hannon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Important: If ite any injury or other 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify, Ardent Crematory 08/31/2010 Hanover, MD of Fureral Service Lice 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc Si natur M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CIALCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buriar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 1 No Yes 2 4 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Dursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours and To the Funeral Hospital Medical 29a. Certifier 🗜 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Ridge Rd. V00

31. Date filed (Month, Day, Year) AUG 31 State Registrar

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8 Пач **Physician** 21:52 M 5 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor land General Hospita Baltumore MD 8. Date of Birth Month, Day If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreig Country) **Funeral** Months Days Hours 1 □ M 2 □ 7634 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Tyes 2 No Director HMOW 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 40 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ennium 17. Father's Name (First, Middle, Last, 18, Mother's Name (First, Middle, Maiden Şyrname) Be P 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Q More non 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MD 2120 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Exam the burial-tran Division or Vital Records, P.O. Box 68760≥ Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 s been signature should to 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 s autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No Medical Certification: To 1 Yes 1 Inpatient ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 No hours after death. uneral Director; / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

emkin, MD.

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Kaltimore IOWSOX 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours **Director** Usual Residence of Decedent or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Nes 2 No It's more 10e. Street and Numbe 10g. Citizen of What Country? or items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) bamble æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental is marked ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of ∠Dat∈ 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such scardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a disease or condition Medical resulting in death) Due to (or some concerned of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death Yes 2 No ed by the a detached i g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Moglth

son who completed cause of death (Item 23a) (Type, Print)

lichael Johnson		State of Mar	yland / Department o <i>Certificate o</i>		l Hygiene	2010	2727
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	- John Marco	T Deall	2. Date of Deat	eg. No.	of Death
dical Exami		Michael Joh	nSon		Month August 20	, 2010	7 hrs
£		4a. Facilify Name (if not institution, give street and 1637 Healthfield Road	1 number)	4b. City, Town, or Location of [Baltimore	Death	4c. County of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2	4Hrs. 8. Date of Birt	th(MM/DD/YYYY) 9. Birthplace (S	State or
Director		220-78-7664 1 mm 20	50 Yrs	Months Days Hours	Min.	7 1960 Foreign Country)	MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Local	lian	7		'a City Limite
. š		M NA		imore			ide City Limits
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	^	10f. Zip Code	10	Og. Citizen of What Country?	
with the Maryland ms 23a or 28a-f sho be notified at once		203 Swale	Ave	21225		USA	
ath with tems 2 st be m	Funeral		d Forces? If Y	as Decedent of Hispanic Origin? es, specify Cuban, Mexican, Po	(Specify Yes or No-	14. Race - American India White, etc.	n, Black,
fter des		3 Widowed 4 Divorced If Yes, Give		Yes 2 No specify:		specify: Black	(-
ours a	od be	15. Decedent's Education (Specify only highest	grade completed) 16a. Deceder	nt's Usual Occupation (Give kind		16b. Kind of Business/Industry	
36 in 72 h han "r dical E	ompleted	Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)) isable	e retireu)	MA	
5-0036 iled within 7 Hygiene. I other than the Medica	Com	17. Father's Name (First, Middle, Last)			lame (First, Middle, M	laiden Surname)	
21215 nuld be file Mental H marked o	Be		nson	Wilr	na Ha	milton	
O 용 점 'a :폭	٩	19a. Informant's Name/Relationship (Type, Print) Antonnette Saure		C 1 A .	. 1)	ber, City or Town, State, Zip Code	
and and fealt fealt	ŀ	20a. Method of Disposition	20b. Place of Dispos	SWALL HU	Date ,	1 MSC, MD 2 20c. Location - City or Town, Sta	1225 ate
Baltimore, bernit. Pages I an Department of He Important: If ite		1 Burial 2 Cremation 3 Remova		ner place)	3/27/2016	Baltimore	MD
Baltimore permit. Pages 1 Department of F Important: If injury or other		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	1 22. N	lame and Address of Facility	1/2010 1/2010	FLIMORA &	Home
- 14		Drall Howl	4 2/ - 40	00 Liberty	Heights 1	Ave, Batto MI	21207
Physician /Medical		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.		, 0	. ,	Betwee	imate Interval en Onset and Death
Examiner			rtensive atheros is a consequence of):	sclerotic card	lovascular	disease	Deatt
	-	Sequentially list conditions, if any, leading to immediate b.	s a consequence of);				
	miner	rany, leading to immediate Due to (or a cause. Enter Underlying Cause (Disease or injury that initiated c	s a consequence or,				
हैं ह ल	Exal	events resulting in death) Last Due to (or a	s a consequence of):				
be executed initial and unial - trans	dical	X UNPENDED . AMENDE	23a,27,per ME g9	100 10///10 TT			
	wr	IF FEMALE: 23c. If ye	es, outcome of pregnancy			23d. Date of delivery	
Box 6876 death certificate the attending phy ed for use as the b	sician/M	past 12 months?	anont at time of death	al death 3 Ectopic pre ner <i>(Specify)</i>	egnancy	Month Day	Year
Bo le deat the at	ᇍ		known				
, P.O. irres that the signed by	by P	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the cause 2 No 3 Probably 4	_
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e law re chas be	Completed				autopsy perform	y prior to completion death?	of cause of
Division of Vital Records, tal or Attending Physician: The law require as after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be a	a l	25. Was case referred to medical		26.Place of Death (Che	1 Yes 2	No 1 ✓ Yes 2	2 No
Vita hysicia this ce	L B	examiner? 1 V Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatient	Other: C		tesidence 6 🗸 Other: Scene	
fing PI	ä	1 V Natural (Mo	ate of Injury nth, Day, Year) 28b. Time of In		28d. Describe ho	ow injury occurred	
Division ospital or Attend hours after death uneral Director:	Certification:	2 Accident Investigation	ace of Injury - At home, farm, stree	1 Yes 2 No	20s Legation (St	to a Marchael Pourol Pouro	City
Divi	ertifi	3 Suicide 6 Could not be determined (Special		t, factory, office building, etc.	or Town, Sta	reet and Number or Rural Route Nate)	lumper, Gity
Divis To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying Physician: To the b	pest of my knowledge, death occurr				
To the within 2 To the complet	BL	and manne	is of examination and/or investigati r stated.				
,	≥	29b. Signature and title of certifier	`	29c. License number O.C.M.E.	COLUE	29d. Date signed (Month, Day, Ye August 21, 2010	ar)
J. J.	1	30. Name and address of person who complete ca	Q TR, M. D,	0.0		August 21, 2010	
June 1		The second secon	0	111 Penn Street, Baltim	ore, MD 21201		
Sta Registr	_	31. Date filed (Month, Day, Year) 32.	Registrar's Signature				

DHMH 17 Rev 1/2001

ORIGINAL

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State of Manyland / Department of Health and Mental Hygiene

		-	For State Registrar		State of M	arylan	•		of Healt		vientai Hy	/gien _{Reg. N}	~ ~	0	27	271	
	Diversisis	/	Decedent's Name	e (First, Middle, La	ast)	•					2. Date of De	eath		Year _	3. Time o		
	Physicia Medic			n C. Jaco							AUG	2	8 3	2010	5:1	7-PM	
	Examin	er			re street and number)		4b. City, Town, or Location of Death BALTIMORE						4c. County of Death				
17	Funeral		5. Social Security No	umber 6.5	Sex 7. A9		ast birthday)	If Under 1	Year If Un	der 24 Hrs.	8. Date of Bi			9. Birthpl	ace (State	o <i>r Foreig</i> n	
	Director		216-24-88	383	1x M 2 □ F 8	31	Yrs.	Months	Days Hour	S WIIII.	April 1	l, rear	929 1	Count Mary	land		
-	nd how at	ᅵᅵ	Usual Residence of 10a. State	10b. County	· -	10c. Cit	y, Town or Lo	cation	•	-	-			10	d. Inside C	City Limits	
	farylar Ba-f s tified	Director	MD	Balt	imore		Caton	sville	3						1 🗌 Ye	s 2 No	
	the N or 28		10e. Street and Nun	nber				10f. Zip C	ode			10g. C	Citizen of WI	nat Count	ry?		
	h with	Funeral	6202 Gil	lston Par				2122				US	A				
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 Never Marri 3 Widowed	ried 2 Married	12. Was Decedent B Armed Forces? 1 🙀 Yes 2 🗌 If Yes, Give Year or Dates.				nt of Hispanic Cuban, Mexi		ecify Yes or No Rican, etc.)		14. Race Black, Specify:	White, e		•	
5-0	2 hour	plet	(Spe	15. Decedent's lecify only highest g			16a. Deced	dent's Usual kind of work	Occupation done during n etired)	nost of work	ding	16b.	Kind of Bus	iness Ind	ustry		
121	thin 7 ene. than he Me	Completed	Elementary/Seco	onday (0-12)	College (1-4 or 5	5+)	Engine	ONOTuser e erin g	Analys	st		Ba1	timor	e Ga	s & EJ	lectri	
d 2	iled w Hygi other	Be	17. Father's Name (F	First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		1		18. M	other's Nan	ne (First, Middle	, Maider	n S <i>urnam</i> e)				
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Mar	shound and 7 is market		19a. Informant's Na	, ,							al Route Number						
e,	and 2 Healtl tem 2		Lynn Brov 20a. Method of Disp		ghter	20b. F	Place of Dispo			T	Date		Location - C				
JO H	age 1 ent of nt: If i		1 ⊠ Burial 2		Removal from State	l c	emetery, cren	natory or oth n Mem	er place) . Garde i	9/4/	2010	Ma	rriot	tsvi	11e, 1		
Balti	permit. F Departm Importa any inju		21. Signature of	~//	- 1110		22 Fi	Name and ineral	Address of Fa Home Mondso	of Car n Aver	erling tonsvil nue; Ca	Asht le, tons	on Sc Inc sville	hwab . MD	Witz 2122	ke 8	
			23a. Part 1. Enter the	the disease, or con	nplications that caused one cause on each line	the deat									Approxima Interval Be	ate	
	h_sician/		Immediate Cause (disease or conditio	(Final	METAS		IC SA	IALL	CELL	CAN	CER				Onset and	Death	
	Medical Examiner		resulting in death)	ſ	Due to (or as		uence of):										
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760	physic the b	edical			d												
89	certific nding use as	Ž/u	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome] F					23d. Date	of deliver	y		
Box	death le atte ed for i	Physician/M	in the past 12 r	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pre Other (spec					Mont	h I	Day	Year	
0	at the		9 Unknown		contributing to death b	out not res	ulting in the u	nderlying ca	use aiven in P	art I.	23e Did t	obacco	use contrib	ute to the	e cause of o	death?	
ο. σ.	res tha	d by	Tarrin Galer eighn					,,,,,	J				2 🗆 No 3			-	
S G	requi been should	lete			,	•					24a. Was		24b. We	ere autop	sy findings	available	
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五二	sician: The la certificate ha lirector, page 2	BeC	25. Was case referre						26. Place of I	eath (Chec		2 4					
10 ×	hysic this ce al direc	유	1 □ Yes 2 Ū	Z No			ER/Outpatier			Nursing H	ome 5 Resi						
J.	ding F th. After funer	cate	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of inju (Month, Dat	y, Year)	injury	M 280	. Injury at work? 1 ☐ Yes 2	! □ No	28d. Describe	now inju	iry occurred				
Acoらし,Jo 中心 C Division of Vital Records, P.O. Box 68	Atten	Certificate:	3 Suicide 4 Homicide	Investigation 6 Could not determined	be 28e. Place of Inju						28f. Location (or Rural I	Route Num	ber,	
JACO & I Division	ital or irs afte al Dir led in				building, etc	s. (Specify	<i>,</i>				City or To	wii, Stat	e) 				
10	To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or invest	tigation, in my	opinion, deat	h occurred a	t the time, date	and plac	e, and due t	o the caus	se(s) and ma	anner stated.	
	Fo the within Fo the comple	Σ	only one) 3 29b. Signature and		rse Practioner: 10 the	best of my	/ knowledge, c		icense numb		ce, and due to ti		ate signed (
			18	a co	MD			P	2348	38		X u(7 28	3,2	010		
,	10+1		30. Name and addre	ess of person who	completed cause of d	eath (Item	23a) (Type, P	Print)	1.	. 0	100	110	00				
\ 			NANA A	th, Day, Year)	t, GEOS C	ar's Sione	ure J	, bal	tim or	2,1	VID Y	42	27.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27272 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /onth Barbara Johannes Lynn 20:72 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hospital tomore Social Security Number . Age (In yrs. last birthdav) If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan 24, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔽 🗗 Months Days Min. Hours 63 Director 218-46-5284 Country) Maryland 1947 Usual Residence of Decedent shov "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 24 W. Franklin St. 21201 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha 11 Bartender/Waitress Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Allen Harlen Johannes Hattie Isabella Kohlhaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Riley /Sister 3470 Ray Rd. Oxford, MI 48370 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date Aug 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 30 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2010 21. Signatune of Funeral Service Licensee 22. Nan@remaid:som Familia Funeral Alternatives MO644 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. En et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) onceme Medical Due to r as a consequence of): Examiner sistant Enterococcu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed ed by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 🗌 Yes Hospital or Attending Physician; 7 24 hours after death. Funeral Director: After this certifice within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifi-29c. License number d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

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		artment of Health and Mental Hyg tificate of Death	iene2010 27273
Physicia /Medica	1 40 Foolikk Name (Knot institution also as a second as I	Kim 2. Date of Death Month August	Day Year 22:09 M
Examine Funeral	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Ab. City, Town, or Location of Death Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign
Director	591-16-3593 1 □ M 2 🛛 F 75 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, Day, 5-20-	Year) Country APAN
the Maryland 7 28a-f show notified at	los. dity, form of 200	cumbiA	10d. Inside City Limits 1, ★ Yes 2 □ No
fter death with r items 23a or iner must be i		Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Og. Citizen of What Country? USA 14. Race - American Indian,
hours after ural", or its	3 PrWidowed 4 Divorced If Yes, Give Year or Dates:	☐ Yes 2 No Specify:	Black, White, etc. Specify: ASIAN
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	lent's Usual Occupation kind of work done during most of working IO NOT use retired) LHURAEEUR	Food SERVIKE
Maryland of 2 should be filed to and Mental Hyg 77 is marked other traumatic event,	17. Father's Name (First, Middle, Last) INIUNG JO ICING	18. Mother's Name (First, Middle, N	KIM
Mar nd 2 sho ulth and 27 is m	MARY NAPIER 8811	g Address (Street and Number or Rural Route Number, 7 ShINING OCEANS WA	Y Columbia Med Dicis
	4 □ Donation 6 □ Other (Specify) AR DENE C	REMATORY 8-27-10 1-	
Balt permit. Depart Importa any inji	23a. Part, taker the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	Name and Address of Facility # USE F 220 Gull FUKG Rd cr r the mode of dying, such as cardiac or respiratory arres	IESSUP, Md 20794 st, Approximate
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Un Cancer Due to (or as a consequence of):		Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause Et at Undertying Cause (Disease or injury		
be e cian cian buris			
x 62 certific ding p use as		Ectopic pregnancy	23d. Date of delivery Month Day Year
. 0 0 0 0		Other (specify)	acco use contribute to the cause of death?
v require		1 Ves 24a. Was an	24b. Were autopsy findings available
clan: The I	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	✓No 1 ☐ Yes 2 ☑No
tending Physicath. The funeral director for After this of the funeral director cation: To cation: To cation:	1	3 DOA Other: 4 Nursing Home 5 Residence 28c. Injury at Work? M 1 Yes 2 No	ce 6 Cother (Specify) injury occurred
tal or Attending P rs after death. al Director: After ted in by the funeration: Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)		et and Number or Rural Route Number, State)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (check only one) 1 **Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inverse and manner stated.	stigation, in my opinion, death occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
_	29b. Signature and title of cartifier AD Name and address of assessment as a selection of the little of the littl	RES -000	August 23, 2010
9 State	30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	600 North Wolfe	e St, Baltimore, MD, 21287
Registrar	31. Date filed (Month, Day, Year) AUG 31 2010 32. Tegistrar's Signature AUG 31 2010	What	

			For 1 = State Registrar	Pleas			nd / Depa	artme	nt of H	Ensure A lealth and I Death			2010	27274
	ıysici: Medic	_	Decedent's Name	e (First, Middle, I	_ast)		Korz	ZEN	iow	SKA	2. Date of Do Month August	eath Da	ay Year	3. Time of Death 20:31 PM
	kamin		4a. Facility Name (If	4				4b. Cit		r Location of Death	1	ath MERY		
Fun Dire	neral ector		5. Social Security No INFANT	umber 6	Sex 1⊠M 2□F	7. Age (In yrs.			ler 1 Year	If Under 24 Hrs. Hours Min. 2	8. Date of Bi (Month, Di Aug 14	rth ay, Year , 20	irthplace (State or Foreign Country) Y Land	
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lary land ZIZIS-UUSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show	xaminer mu	by Funeral	11. Marital Status 1 ⊠Never Marri 3 □ Widowed		Armed F	2⊠ No Sive			edent of Hoecify Cuba 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh	ite, etc.
i 3-0030 n 72 hours af "natural", or	edical	Completed		15. Decedent's ify only highest of	rade completed		16a. Deced	dent's Us kind of N	sual Occup vork done	eation during most of wor d)	king	16b. F	Kind of Business	s/Industry
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VIAND VIId be file Mental Hy arked othe	atic event,	To Be C	17. Father's Name (Marek l	First, Middle, La Karzenjo						18. Mother's Nan Agnies:	ne (First, Middle zka Korz			
Mar d 2 sho th and 17 is ma	traum		19a. Informant's Na Agnieszka			- mother		_		and Number or Ru e Lane A				Zip Code) MD 20850
Dallimore, Maryiar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked	y or other		20a. Method of Disp		□Bemoval from	20b. I	Place of Dispo cemetery, crea	sition //	ame of	· ·	Date		ocation - City o	
Dallingor Department of Mportant: If it	any Injur once,		21. Signature of Fun	1		/	. 22			ss of Facility St		-		ND 21201
Physic /Med	cian Iical		23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	Final	a	caused the deal each line.	true		ode of dyir	ng, such as cardiac			TETMOTE	Approximate Interval Between Onset and Death
Exam		iner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nditions, mediate rlying	b. Due to	o (or as a consec	juence of):							
oo rou, ificate be executed physician and	the burial-tran	dical Examiner	that initiated events resulting in death) L	ast	c Due to	o (or as a consec	juence of):							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1□Live	utcome pf pregn birth 2 □ Feta gnant at time of c nown	aldeath 3□]Ectopic] Other	pregnancy (specify)	/			23d. Date of de Month	elivery Day Year
aw requires that is been signed b	uld be deta		Part II. Other signifi	icant conditions	contributing to	death but not res	ulting in the u	nderlying	g cause giv	en in Part I.	1		_/	to the cause of death? Probably 4 □Unknown
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sician s certifi	irector	Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☑	/	Hospital: 15	Inpatient 2	ER/Outpatier	nt 3⊡ l	Oth Oth	26. Place of Dea	ith <i>(Check only</i> ome 5 ☐ Res		E DOthor /Sa	posific)
nding Phy th. : After this	e funeral d	ation: To	27. Manper of Death 1 ☑ Natural 2 ☐ Accident		28a. Dat	e of Injury onth, Day Year)	28b. Time o		28c. Injur Wor	4 LINUISING H	28d. Describe			ecity)
LIVIS tal or Atte s after des al Directo	ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Plac buil	ce of injury - At h ding, etc. (Special	ome, farm, str	eet, fact	ory, office		28f. Location (City or To			Rural Route Number,
e Hospi 24 hour e Funera	letely fill	Medical (aminer: On the					me, date and place opinion, death occu				
To th To th	сошр	Me	29b. Signature and	title of certifier	Peigel	2		2	9c. Licens				ate signed (Mor	
۶.			30. Name and addre		o completed car	use of death (Iter	n 23a) (Type,	Print)	CK AV	26246 e Gaith	ersh na	m	8/15/1 D 208	77
Re	Sta egistr	te ar	31. Date filed (Mont			Registrar's Signa	atule 4	ake	1	· • · · · · · · ·				

DHMH 17 Rev 1/2001

Boy-A

State State AMEND 1 7 PER DR. G907 9/24/10 KH Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** ALEX LIN, JR. 11:22 AM Baby Boy Kao 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Months Days 33 Hours 1**X** M 2 □ F Maryland July 13, 2010 Director INFANT Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Rockville MD Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 USA 10603 Mist Haven Terrace by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ANever Married 2 Married Specify: asian 1 ☐ Yes 2 🗷 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than ' College (1-4or 5+) INFANT Elementary/Secondary (0-12) INFANT INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yihder Lin Tzuwan Kao ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10603 Mist Haven Terrace; Rockville, MD 20852 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Tzuwan Kao - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State . Signature of Euneral Ser 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death 3a. Pa Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fallure. List only one cause on each line. Immediate Ca Final disease or condition resulting in death) Physician Mecr /Medical Examine pre ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list age are to a list and the l Examine physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached fo 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 ☐Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending Injury 1 □ Yes 2 🗌 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. investigation 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and August 16,2010 and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE Ros MD 31. Date filed (Month, Day, Year) AUG 3 1 2010 State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:39 AM Shreemathy Kamakshi August 2⁶, 201⁰ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2000 Eastridge Road Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X F Alerth, Day, ່ 1 9 24 India N/A 86 **Director** Usual Residence of Deceden or 28a-f shov 10a. State 10b. County artment of Heatth and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director -201 MD Baltimore Timonium 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Eastridge Road 21093 India 00 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc ģ Never Married 2 Married Baltimore, Maryland 21215-0036 Hindu If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Treemathy Karmakshi 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) School System Social Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ramaswami P. Ayyar ည Kamalambal Iyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau Ariun Malik-brother 2007 Dumont Road-Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Evans Funeral Chapel
and Cremation Ser Belair 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Aug. 27, 2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Service 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and Douth Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after ceath.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: မှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of D th

Natural

Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \sum Yes 2 \sum No (Month, Day, Year) injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner/To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ap 29d. Date signed (Month, Day USLIA

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

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		4	State of Maryland		artment of Hea tificate of Dea			giene 2010	27277	
			Registrar 1. Decedent's Name (First, Middle, Last)	th	3. Time of Death					
	Physicia Medic		Paul P. Kohorst				28 201	0 11 a M		
-	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc			4c. County of Dea Baltim			
Samuel Control			Arden Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. le	ast hirthday)	Pikesvi	Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign	
	Funeral Director		480−18−6502 1 M 2 □ F 88	Yrs.		lours Min.	057307		untry) Iowa	
			Usual Residence of Decedent 10a State 10b, County 10c, City	y, Town or Lo	antian				10d. Inside City Limits	
	nyland I-f she ied at	cto			tt City				1 ☐ Yes 2 🎛 No	
	ne Ma or 28¢	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?	
	with t	Funeral Director	9328 Meadow Hill Road		21042			United St	ates	
	death items	표	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
36	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 4 Divorced Saw Year or Dates.	15	1 ☐ Yes 2 🔀 No S	Specify:		Specify: Wh	ite	
21215-0036	hours natura lical E	Completed	15. Decedent's Education	16a. Deced	dent's Usual Occupatio kind of work done durir	on	20	16b. Kind of Business	Industry	
218	iin 72 ie. han "l	d wo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Ìife. D	O NOT use retired)	ng most of worth		G	and the Admin	
	filed within 7 tal Hygiene. d other than event, the M	BeC	2 17. Father's Name (First, Middle, Last)	Mai	nagement	B. Mother's Name		SOCIAL SEC Maiden Surname)	urity Admin.	
auc	uld be file Mental I narked o natic eve	6	Joseph H. Kohorst		I .	Mary E.				
ā	shou and is n		19a. Informant's Name/Relationship (Type, Print) Constance M. Ahlquist/Daughter	19b. Mailii 9328	ng Address (Street and Meadow Hil	Number or Rura	Route Number	; City or Town, State, Z.	ip Code) 1042	
	l and 2 s f Health item 27 other tra		20a Method of Disposition 20b. F	Place of Dispo	osition (Name of		Date	20c. Location - City o		
<u>o</u> E			Burial 2 Li Cremation 3 Li Removarilom State		For. Vet.	09-0	2-2010	Owings Mi	lls, <u>MD</u>	
Baltimore,	permit, Page 1 and 2.8 Department of Health Important: If item 27 any injury or other tri		21. Signature of Funeral Service Licensee M01()44 ²² 43	2. Name and Address of 112 Old Col	^{of Facility} Har lumbia P	ry H. W ike Ell	litzke's Fa licott City	mily FH Inc. , MD 21043	
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on pach line.	h. Do not ent	er the mode of dying, s	such as cardiac o	r respiratory arr	rest,	Approximate Interval Between	
	hysician/	y)	Immediate Cause (Final disease or condition	me.	cls DI	Sease			Onset and Death	
-	Medical Examiner		resulting in death) Due to (or see a sequence of the control of t	uence of):)	
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions).	uence of):						
	ate be executed bhysician and the burial-transit	dical Examiner	cause, Enter Underlying Cause (Disease or linjury that initiated events c.							
	e exec cian al ourial-t	alE	resulting in death) Last Due to (or as a consequence of the consequenc	uence oi);						
200	cate b physi s the b	edic	d							
.89	eath certificat attending ph I for use as th	Jan /M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fets	ancy aldeath 3	Ectopic pregnancy			23d. Date of d		
Box 687	death he atte	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown Unknown		Other (specify)			Month	Day Year	
P.O.	requires that the der been signed by the should be detached	y Phy	Part II. Other significant conditions contributing to death but not res	sulting in the	underlying cause given	in Part I.	23e. Did to	obacco use contribute t	to the cause of death?	
S, F	uires ti n signi ild be	q pe					1 🗆	Yes 2 ☐ No 3 ☐	Probably 4 Unknown	
oro	w require been so shou	plet				24a. Was	prior to	utopsy findings available completion of cause of		
Rec	rsician: The law r s certificate has k lirector, page 2 s	S S			. <u></u>			ormed? death?	es 2 🗆 No	
tal	ician: sertific ector,	Be	25. Was case referred to medical examiner?		_ Other	e of Death (Check			3	
Ϋ́	Physic ruthis eral dir	2	1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of injury	28b. Time o	of 28c. Injury at	4 Nursing Ho		dence 6 🔀 Other (Spenow injury occurred	offy)asst. LVg.	
on C	nding ath. r: Afte ie fune	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	M 1 ☐ Ye	es 2 🗆 No				
Division of Vital Records,	or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specification of the country)	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,	
Ō	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical (29a. Certifier 1 XCertifying Physician: To the best of my know	/ledge, death	occured at the time, da	ate and place, ar	nd due to the ca	use(s) and manner as s	tated.	
	he Ho in 24 I he Fur	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of m	on and/or inver ny knowledge,	death occurred at the ti	ime, date and plac	t the time, date a ce, and due to th	e cause(s) and manner a	is stated.	
	mestine Wright DS2/40 Aug 30, 20									
2			30. Name and address of person who completed cause of death (Iter	3 13	laney Vo	illey 1	(cad)	Invanion	MD 21093	
	Sta		31. Date filed (Month, Day, Year) ALIC 3 1 2010	ative A	wed	J	- 7			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month COCZOROWSK 09:59 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖺 F Days Min Dec 6,1923 Hours 218-18-4495 86 Maryland Director Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f Md. 1 Str Yes 2 No Baltimore City 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 304 South Durham Street 21231 U.S.A. items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i Black, White, etc. 1 XNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Koczorowski Catherine Szumska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Delvale Avenue Baltimore, Md. 21222 Catherine Nowak - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State August emetery, crematory or other place)
Ly Rosary Cem. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Holy 30,2010|Baltimore,Maryland 4 Donation 5 Other (Specify) Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset an Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in redicto cause. Enter Underlying Dusity (or as a consequence or). Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2XXNo Other: 잍 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗆 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 Dag 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Herror

31. Date filed (Month, Day, Year)

AUG 3 1 2010

Avenue, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:52 AM ugust Allen Longanecker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 K M 2 D F Months Days Hours Min. (Month, Day, 220-42-3188 Feb Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Millersville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8248 A Woods Rd. 21108 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 X Divorced Specify: Year or Dates 63 - 6715. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Α. Longanecker Sr. Agnes Krua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7736 West Oxeye Place Homosassa, Fla. 34448 Agnes Longanecker (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc, 8/26, 2010 Baltimore, Md. 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest p. List only one couse on each line. 23a, Part 1. Enter the di Approximate shock, or heart failure.

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Physician. Medical Examiner

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as

attending physiciar

signed by the a

this certificate has page 2

funeral director.

сотрете filled in by the

To the I within 2

Certificate:

Medical

P.O. Box 68760

Division of Vital Records,

Physician/

Medical

10a. State

Md.

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

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28a-f

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or items 23a

"natural"

Baltimore, Maryland 21215-0036

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event, the Medical Examiner must be notified at

Immediate Cause (Final disease or condition resulting in death) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and

21. Signat

Se uentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medica Be examiner? မ 1 🗆 Yes

Due to (or as a consequence of):

Pregnant at time of death

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Ectopic pregnancy

5 Other (specify)

23d. Date of delivery Day

24a. Was an autopsy

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown

Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

28f. Location (Street and Number or Rural Route Number,

			2	26. Place of Death (Check only one)						
tos	spital:		_ 1	Other:						
_	1 Inpatient 2	ER/Outpatient 3	☐ DOA	4	☐ Nursing H	ome 5 Residence	6 Other (Specif			
	28a. Date of injury (Month, Day, Year)	28b. Time of injury		Injury at work?		28d. Describe how inj	ury occurred			

M 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

City or Town, State) Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 在 M.D tugust 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30

5 Pending

Investigation

determined

6 Could not be

2 No

. Mann of Death

Natural

2 Accident
3 Suicide
4 Homicide

29a. Certifier

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ ADAM T. LESNIEWSKI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE KLOSHNGTON MASKAL ENTE2 GLEN BUP ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 M 2 🗆 F Months Days Month, Bay, 4955 89 Director 12 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1169 Wharf Drive 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Turnbull College (1-4 or 5+) Machinist Enterprises Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, BLNIEWS IT should be file and Mental H မ Stanley Lesniewski Stella Czastkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joanne Houck – daughter 1169 Wharf Dr. Pasadena, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 8/31/10 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee GJ Gonce Funeral Riviera Dr. <u>Pasadena.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ VEUN disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner nding physician and use as the burial-tran Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 0 in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day signed by the at the detached for Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes 2 Accident 2 🗌 No Investigation completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier 29b. Signature 45149 the and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per FH G906 8/31/10 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Δ^{Month} Physician/ Year 2,00p M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10 More 8. Date of Birth A (Month, Day, AuGust **Funeral** Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2 🔽 Months Days Hours Min. Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits 1 Nes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: 1 CRC Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 100r 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 n Holly 2170 20a. Method of Disposition 20b. Place of Disposition (Name of Dat 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State crematory or other pla 4 ☐ Donation 5 ☐ Other (Specify) MARU Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eD tome BaTTO 4600 LABERTU 10216 am 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 car disease or condition resulting in death) Medical Examiner abetla Securetially list our 1th on Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 9 Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.
9 Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a con quence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Morbid Oko sity Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ၉ 1 🔲 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Could not be 1 ☐ Yes 2 ☐ No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Z85 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 724 Maiden Choice eduvina Baltimore Md.21228 31. Date filed (Month, Day, Year) . Registrar's Signa State **AUG 31** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Therese M. Molony 2°0°10 Aŭgust 4:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll 6317 Oklahoma Road Sykesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Days Hours Feb 17 Year 1929 Director 030-22-3004 81 Yrs Massachusetts Usual Residence of Decedent Show 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Ellicott City 1 ☐ Yes 2 🎇 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8700 Ridge Road Apt. 106 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married __ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilfred Lemay Irene Picard permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy M. Molony, Son 20 South Beaumont Avenue Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/02/10 Baltimore National Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Name and Address of Facility ICN abb Funeral Home, P.A. 11 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death IVER METASTASIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown vare has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLI TUS TYPE 11 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has ARTERY DISEASE CORUNARY 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN D 0062704 f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 3290 No Ridge Rood, Suite 100 Desai MD Jo

Registrar

State

31. Date filed (Month, Day, Year)

AUG 3 1 2010

2. Registrar's Signature

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1	4a. Facility Name (if not institution, give street and number) 716 New Bridge Road	4b. City, Town or Location of Dea								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		rs. 8. Date of Birth(MM/DD/YYYY) 9. B	Sirthplace (State or eign Ohio						
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land show d at	ģ	10a. State	10b. County		10c. City, T	own or Loc	ation							e City Limits
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ING 21213-UU30 • flied within 72 hours after death with the Maryland tal Hygiene. •d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at		10e. Street and Nu		10			10f. Zip C				10g. C	itizen of What Co		
ath wi	Funeral	3811 Wa	bash Av	e Apt 1C	ever in U.S.	13. V	/as Deceder	21215		cify Yes or No	-	14. Race - Ame		1.
or ite	3		ried 2 Married	Armed Forces?		If	Yes, specify	Cuban, Mexi	ican, Puerto	Rican, etc.)		Black, Whit	te, etc.	
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IlTIMOTE, Maryla nit. Page 1 and 2 should be artment of Health and Men ortant: If item 27 is marke injury or other traumatic		Burial 2	Cremation 3 D	Removal from State			atory or oth		0/1	21/201	h	Woodla	rrn 1	w 2
Baltimore, permit. Page 1 and Department of Hes Important: If item any injury or othe	ej /	/	uneral Service Licer	-	J_K1D	22	Name and	Address of Fa	acility	517201	<u> </u>	WOOGIA	MILL I	10
Depariment of the policy of th	8	1 WIN	rala c	- Serian		4	300 W		Ave			re, Md	2121	L.5
		mock, or he	art failure. List only	nplications that caused one cause on each line	d the death. I e.	Do not ente	r the mode o	of dying, such	as cardiac o	or respiratory a	rrest,		Approxi Interval	imate Between and Death
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Examin	_		ſ	Bran	a consequer	nce on.							20	aus
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Box death death e	icia	in the past 12 1 \(\sum \text{Yes} \) 2	□ No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Other (spe					Month	Day	Year
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rds, P.O. requires that the been signed by the			utension	contributing to death t	out not result	ing in the d	idenying od	acc given ii i				2 No 3 1		
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Division of Vital Records, tal or Attending Physician: The law requires rs after cleath. In Director: After this certificate has been siged in by the funeral director, page 2 should be	ļ.		No	Hospital:	ient 2 🗆 EF	R/Outpatier	t 3 🗆 DOA	Other: 4	Nursing Ho	ome 5 🗆 Res	idence	6 Other (Spe	cify)	
n of ding Pt h. After th funeral			5 Pending	28a. Date of inju (Month, Da		8b. Time of injury	- 1	c. Injury at work?		28d. Describe	how inju	ury occurred		
IVISION OF VITAI or Attending Physician: after death. Director: After this certific in by the funeral director,	Cortificato.	2 Accident 3 Suicide	6 Could not	be 28e Place of Ini	ury - At hom	e farm str	M eet, factory	1 \(\text{Yes} \)	2 🗆 No	28f Location	(Street a	nd Number or R	ural Route N	lumber.
JIVISIOR I or Attend a after death Director:			e determine	building, et		0, 14111, 061	ot, ladioly,	011100	1	City or To			2700710010	
Div To the Hospital or within 24 hours aft To the Funeral Dir completed filled in	legipo	29a. Certifier (Check	1 Certifying Ph	ysician: To the best of niner: On the basis of	my knowled	ige, death o	occured at the	ne time, date a	and place, ar	nd due to the o	ause(s)	and manner as s	tated.	d manner state
the H hin 24 the Fi	N	only one)	3 Certifying Nu	rse Practioner: To the	best of my k	nowledge,	leath occurre	ed at the time,	date and place	ce, and due to	the caus	e(s) and manner a	s stated.	
viti Sor		29b. Signature and	. ()	marineon	1	MBB		License numb 25 –	er - CCC		29d. L	ate signed (Mon	tn, Day, Year	+ 21 21
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Regi	sırar	70	7 0 T COLO	Lenge	10.	7								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 27286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 27 2010 2010 9:05 P PEGGY ANN MION Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 906 St. Andrews Way Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCt. 9 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 🗆 M 2 🔀 F Maryland 1938 Director 215-34-7591 Usual Residence of Decedent fshow Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 ☐ Yes 2 🖺 No <u>Maryland</u> Bel Air Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21015 USA 906 St. Andrews Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Police Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Bragg Issac Virgil Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3938 Lantern Dr., Silver Spring, MD 20902 Eric Mion / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Duylal 2 X Cyemation 3 Demoval from State Towson, Maryland Other (Specify) Hilltop Service Corp. 8-30-10 21. Signeture of Fur McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Entertife disease, or complications that caused shock, or heart failure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death ANGIOSARCOM Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 1 🗆 Yes 2 🗆 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? To the Hospital or Attending within 24 hours after death. To the Funeral Director, After Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, 2010 who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21207

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 1 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ AUGUST 28, 2010 7:53 A EDNA HAMRIC MUSSER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Oak Crest Care Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Year) 1 M 2 XF Months Days Hours Min West Virginia 231-48-2209 92 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 1 Yes 2 No Maryland | Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8820 Walther Blvd. Room 101 N 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher Public Education Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ pe Roy Oscar Hamric Myrl (nmn) Keener permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. MUSSEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith M. Bailey / Daughter 1315 Marquis Ct., Fallston, Maryland 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🗷 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Woodmere Memorial Park 9-2-10 Huntington, W. Virginia of Funeral Service License McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stace disease or condition Medical resulting in death) **Examiner** ese pra Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. -transit and Due to (or as a consequence of): resulting in death) Last the attending physician and for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Director: After this certificate has been signed by the a in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 2 / No 1 🗌 Yes 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2- No Other: Nursing Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Home 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D58646 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 21231 W(1) Walther 32. Registrar's Signatu State AUG 3 1 2010 Registrar

78

State of Maryland / Department of Health and Mental Hygiene 27288 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Maddox August 28, 2010 10:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10400 Democracy Lane Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year,
June 23, 1 **Funeral** 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Days Hours 1 X M 2 D F 67 **Director** Yrs 217-42-0282 Washington DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at **Funeral Director** MD Montgomery Potomac 1 ☐ Yes 2 X No 9 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 10400 Democracy Lane 20854 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Attorney at Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ John Clarence Maddox Vernon Peck 19a. Informant's Name/Relationship (Type, Print) Domestic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Prather 10400 Democracy Lane, Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory : 8/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD . Signature of Funeral Service Ligensee ²² Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD m00382 Stephit John Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Bacterial Urosepsis week Medical Due to (or as a consequence of) **Examiner** Carcinoma of the Sitm of the Bladder Sequentially list conditions Examine tany, leading to in modification cause. Enter Underlying Cause (Disease or iinjury Disk to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2XX No 3 ☐ Probably 4 ☐ Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as e 2 performe certificate Yes 21 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျှ 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident 2 Accident
3 Suicide
4 Homicide Investigation Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Dav. Year) 08 H58874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20895 Bradley J. Hunter M.D., 10400 Connecticut Ave., Kensington MD 31. Date filed (Month 32. Registrar's State AUG 31 Registrar

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 0 27289 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ a:15 Frederick PRIKST Mouery 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Year) Dec. 29 1913 1 1 M 2 □ F 96 Director 100-12-2528 Usual Residence of Decedent shov 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9007 Ft. Smallwood Road 21122 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Yes Yes altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Boilermaker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Mouery Cusic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Velma Gakenheimer (daughter) Burgess Road, Pasadena, 7800 MD 21122 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 30 1 🗆 Burial 2 屎 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 rematory 21. Signlatur 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, 23a. Part 1. Enter the disease, or c/mpli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on a chiline. nterval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Ropi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury (or as a consequence of) use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law autopsy has 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: ဂ္ဂ 1 Inpatient 28a. Date of injury 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural
Accident
Suicide 5 Pending M 1 🗌 Yes 2 🗆 No Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ZJYear CHAN BYUNG PARIC 1:14 AM AUG Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard HOWARD COUNTY GENERAL INTO PITAL WILLIMB IA 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 692-01-401 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits 0 HOW MR Yes 2 ☐ No 210 KOK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black. White, etc Completed by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 - Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PARK ၉ 19a. Informant's Name/Relationship (Type, Print) et and Number or Rural Route Number, City or Town, State, Zip Code) 2/075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of eral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death SEPTIC SHOUL Physician. Medical resulting in death) Due to (or as a consequence of) Examiner STAPHYLOLDUUS BAUTEREMIA AVROUS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner STAP HYLOCOCUS MUREUS PNEU MONG, A for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year ☐ Pregnant ☐ Unknown Pregnant at time of death 5 Other (specify) Day be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATING MISTRESS SYMPROME 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? PERIUALDIA ERFUSION 24a. Was an autopsy performed? this certificate has page 2 TUBÉROUSIS 1 Yes 2 No 25. Was case referred to medical examiner? Be the funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XVNo Certificate: To 1 🗌 Yes 1 Linpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred After 4 iniury 1 Natural 5 Pending s after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) e Funeral C Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D36974 AUG 28 , 2010

State Registrar

31. Date filed *(Month, Day, Year)* **AUG 3 1 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

O. NYANDOM

32. Egistrar's Signature

16710 CHARTER DR 12310

Counsia mo 21544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M		epartment of F Certificate of		nd Mental Hy	111/11/20	0.1.0				
			Registrar 1. Decedent's Name (First, Midd)	le Last)	2. Date of Death 3-Time of the									
	Physici		Adele K. Phill					August	Day	20 ็ำ ป็	8:10 pm			
and the	/Medic Examir		4a. Facility Name (If not institutio		;)	4b. City, Town, o	r Location of [unty of Death				
nd the	Examin		Charlestown Re	tirement Cen	nter	Cat	tonsvil	.le		Baltim	ore			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birth	Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D	irth Pay, Year)	9. Birth	place (State or Foreign ntry)			
п	Director		219-05-8361	1 □ M 2 🛣 F	94 Y	rs.		12/07/			yĺand			
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits			
	Maryl sho	호	MD Ba]	ltimore		Catonsv	ille				1 □Yes 2 X No			
	r 28a	irec	10e. Street and Number	CIMOLE	1	10f. Zip Code	1110		10g. Citizen	of What Cour	ntry?			
	h with	al D	709 Maiden Cho	oice Lane RG	T215	2.	1228		Un	ited S	tates			
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Modool Evarrather must be northed at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H	Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0- 14.	Race - Ameri Black, White,				
36	or it	by Fu	1 Never Married 2 Mar	ried 1 ☐ Yes 2 🔀 If Yes, Give		1 ☐ Yes 2X No	Specify:				ite			
5-0036	ural"	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1 40- 5	De se dentis Literal Consu	- otion							
5	n 72 "nat	Completed	(Specify only highe	nt's Education est grade completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of d)	f working	Tob. Kind C	of Business/In	dustry			
2121	withi	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Office Wor			Manu	factur	ing			
	al Hyg othe	a a	17. Father's Name (First, Middle,	Last)			18. Mother's	Name (First, Middle	e, Maiden Sur	name)				
/lar	uld be Vienta rrked rifc ev	To B	Clarence Kelly	7				Minnie Ry	all					
Maryland	2 sho and I Is ma		19a. Informant's Name/Relations	ship (Type. Print)		Mailing Address (Street								
	and in an		Walter L. Hoop	per (Son)		0 Mayfair (
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Examiner is ust be rediffed at once.		20a. Method of Disposition 1XX Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place of I cemetery,	Disposition (Name of crematory or other place		Date		on - City or To	,			
tim	t. Pa rtmer rtant: njury		4 Donation 5 Other (S		Parkwo	od Cemeter	<u> </u>	9/01/2010	Balti	more,	Maryland			
Bal	permi Depa Impo any Ir		21. Signature of Funeral Service	Licensee		22. Name and Addre	•	Hubbard						
			23a. Part . Enter the dise se, o	r convilications that cause	nd the death. Do no	4107 Wilks				Maryl	and 21229 Approximate			
			shock, or heart failure. List Immediate Cause (Final	on ne cause on each	line.	2 10	g, 04040 00	177	arroot		Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	s a consequence of	BINIVAN	doler	erry		-				
T	Examiner			Due to (or as	a consequence of	,•		1.0						
		je l	Sequentially list conditions,	b. Dua to (or a	s a consequence of	r.								
	icate be executed physician and s the burial-transit	Examiner	ri arry, leading to infrisdiate cause. Enter Underlying Cause (Disease or injury that initiated events	с										
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9 x	ding page as		IF FEMALE:	23c. If yes, outcome	e of pregnancy				00.1	D 1 ()				
Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		230.	Date of deliv. Month	ery Day Year			
Ö	y the d	Physician/M	1 □Yes 2 □No 9 □ Unknown	9 Unknown	at time of dodn't	з 🗆 Отног (арсолу) _								
Q .	s that ned b	by Pt	Part II. Other significant conditi	ons contributing to death	but not resulting in t	he underlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?			
Records,	quire; en sig uld ba	g pe		preli	Mayne	2		1□	Yes 2	lo 3 ☐ Pro	bably 4 🗆 Unknown			
ည္က	aw re	plet		/				24a. Was			opsy findings available			
Ä	hysictan: The la his certificate ha I director, page 2	Completed						perf	opsy ormed? 2 No	death?	ompletion of cause of 2 □ No			
Vital	stan: ertifica ctor, p	BeC	25. Was case referred to medica examiner?	I			26. Place of	f Death (Check only						
of V	hysic this co	၉	1☐Yes 2☐No		ient 2 ER/Outr		-#T⊒ Nurs	ing Home 5 ☐ Res	sidence 6	Other (Speci	ify)			
ū	ing P	ü.	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir		jury 28b. Tii <i>ay, Year)</i> Inj	ury Wor			how injury oc	ccurred				
Sio	ttend death tor: ,	cati	2 ☐ Accident investi	not be	sium At home form]Yes 2□No		(Chant and M		and Dougla Alexandra			
Division	or A	Certification:	4 ☐ Homicide determ	nined 20e. Place of it building, e	tc. (Specify)	n, street, factory, office		City or To	(Street and N wn, State)	umber or Hun	al Route Number,			
_	spital neral r filled		29a. Certifier 4 Certifyi	ng Physician: To the bes	t of my knowledge,	death occurred at the ti	ime, date and	place, and due to th	e cause(s) an	d manner as	stated.			
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s		or investigation, in my	opinion, death	occurred at the time	e, date and pla	ace, and due t	o the cause(s)			
	To the within To the comp	M	29b. Signature and title of certifie	"In Salle	in n	29c. Licens		rdo	29d. Date si	gned (Month,	Day, Year)			
			•	1		00	35.96	40	8/	3//10				
			30. Name and address of person	who completed cause of	death (Item 23a) (T	ype, Print)	Pen	Chala.	01	ine (Elcan 1			
			31. Date filed (Mooth, Day, Year)		trar's Signature	1 m	and the	wou	t- Ca	The CE	# 4			
	Sta Registr			10 A	trar's Signature	MI)					2/226			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 27294 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 08 Month Physician/ Day 2010 ALBERT Z. PALEWICZ 28 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 306 Bar Harbor Rd. Pa<u>sadena</u> Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 091 34 2886 68 Poland Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits notified 28a-f 1 🗆 Yes 2 🗷 No Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 306 Bar Harbor Rd. 21122 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married 🗌 Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working the and Mental Hygiene.
It is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Test Super. Powercon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leon Palewicz Paulina Department of Health an Important: If item 27 is r any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Palewicz - wife 306 Bar Harbor Rd. Pasadena, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven Mem PK 9/1/2010 Glen Burnie. Glen 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Juneral Sovice Licensee 169 Riviera Dr. Pasadena, Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. nset and De it Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as JE FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ate has been signed by the page 2 should be detached 1 Urknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed' 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 **To th**e Certifying Nurse Fractioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) me

Registrar
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State Registrar 32. Registrar's Si

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			For State Registrar	State of	Marylan		artment of tificate of		and M	lental Hygi Re	ene eg. No20	10	27296
	Physicia	ın/	1. Decedent's Name (First, Middle,	Last)						2. Date of Death Month	Day	Year	3. Time of Death
	Medic	al	Dorothy 4a. Facility Name (if not institution, o	G.		ape				August	28, 20	10	8:25 P M
	Examin	er	646 Round Hill		<i>jer)</i>		4b. City, Town,	or Location \circ			4c. County		undel
	Funeral		5. Social Security Number 6	S. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birth		g. Birthp	place (State or Foreign
	Director		153-10-1556	1 □ M 2 🔀 F	9	0 Yrs.	Months Day	Hours	Min.	(Month, Day,) Jan. 01	1920	Coun	NJ NJ
	nd how at	Ž	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation					1	0d. Inside City Limits
	faryla 8a-f s tified	rect	Maryland Anne	Arundel			Gik	son I	sland	ì			1 ☐ Yes 2 ☑ No
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	h with	Funeral Director	646 Round Hill					2105				USA	
	r deat r iten iiner r		11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Deced	ces?	S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Ori ban, Mexicar	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		e - Americ k, White, e	
036	safte ral", c Exam	q pe	3 ☑ Widowed 4 ☐ Divorced	ed 1 Yes If Yes, Give Year or Dat		1	☐ Yes 2 🖟 N	o Specify.	•		Specify:	W	nite
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Completed by	15. Decedent (Specify only highes	's Education			lent's Usual Occi		t of workir	ng I 1	16b. Kind of Bu	usiness Inc	dustry
12	within 72 /giene. ner than '	mo	Elementary/Seconday (0-12)	College (1-	4 or 5+)	life. Do	NOT use retire Ban	d)	t or works		Padara	I Don	erve Bank
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<u>lan</u>	d be fil fental irked tic ev	욘	Albert Gi	nette				1	mie		nio	,	
Maryland	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailin	g Address (Stree	t and Numbe	er or Rurai	Route Number, (City or Town, S	tate, Zip C	Code)
	1 and 2 shuft Health an item 27 is other trau		Carolyn Keenen 20a. Method of Disposition	(daugh				ill Ro		Gibson I			
Jor	age 1 and of h		1 Burial 2 🖾 Cremation		State 0	emetery, cren	sition (Name of natory or other pi ematory	ace)	Aug.	31	20c. Location -	•	wn, State Maryland
Baltimore,	permit. Page 1 and Department of Hamportant: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service Like			\rightarrow	. Name and Add			10			
ñ	permit Depar Impor any in		Musahell	Stall	lix	ノー			-	id, Pasad			ome, P.A. 122
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (a	r as a consequ	ianca cty:							
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events	C								_	
_	cate be executed physician and s the burial-transit	alE	resulting in death) Last	Due to (d	r as a consequ	ience or):							
Box 68760	icate by physical phy	ledical		d							_	\perp	
89	certif ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			Ectopic pregna	nev			23d. Dat	te of delive	ery
B 0	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		ant at time of d		Other (specify)				Mo	nth	Day Year
P.O.	at the od by t detach	Phy	Part II. Other significant condition	l s contrib∕uting to de	ath but not res	ulting in the u	nderlying cause	given in Part	1.	23e. Did toba	acco use contr	ibute to th	e cause of death?
S, F	ires the signered be de	Completed by	Atrin	redit	Mut	-w-				1 ☐ Yes	s 2 🗆 No	3 🗆 Prot	pably 4 Unknown
of Vital Records,	v require s been s s should	olete		1						24a. Was an		Vere autor	osy findings available
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<u>e</u>	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?					Place of Dea	th (Check		7		
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n o	ding F h. After funera	cate	27. Manner of D th Thattural 5 □ Pending 2 □ Accident Investiga		i injury i, <i>Day</i> , Year)	28b. Time of injury		ıryat rk? ∐Yes 2 [.8d. D esčribe how	v injury occurre	ed	
Division	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	2 Accident Investiga 3 Suicide 6 Could not 4 Homicide determin	ot be 28e. Place of			et, factory, office		-	28f. Location (Stre		er or Rural	Route Number,
Οį	ital or irs afte ral Dir			building	g, etc. (Specify)					City or Town,	State)		
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical Ex	Physician: To the be aminer: On the basis lurse Practioner: To	of examination	and/or invest	igation, in my opin	nion, death or	curred at	the time, date and	place, and due	to the cau	use(s) and manner stated.
	To th withir To the comp	2	29b. Signature and title of certifier	The second in				se number			d. Date signed		
	1		M	5			リリ	192	1		8/3	0/10)
0			30. Name and address of person w	no completed cause	of death (Item	23a) (Type, P	Q M	1.	VA	Pan	1000	Nina)	1. 11122 -
	Stat	te	31. Date filed (Month, Day, Year)		gistrar's Signat	ure	o rie	WENT	1 CE	- 1 W J L	COM, I	MINI	INF LILL

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27297 Edna Quaresma State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 26, 2010 **Medical Examiner** 0927 hrs aresma 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours Min. 2**X**F 62-Country) 1 M Yrs 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 27 is marked other than "natural", or items 23a or 28a-f sho umatic event, the Medical Examiner must be notified at once. 5e death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 2 X No 1 Yes Pages 1 and 2 should be filed within 72 hours after vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. 3 X Widowed 4 Divorced Yes, Give Year 1 Yes 2 No specify: þ r Dates: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5-0036 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, M Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ဥ Muhammacı Newark NJ 07108 20b. Place of Disposition (Name of cemetery 20c, Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Grove Donation 5 Other Specify 5 22, Name and Address of Facility
Vaughn Gree
5151 Baltmore Signature of Funeral Ser vice Licensee Funer reene 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease) Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tran sician/Medical the attending physician and for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth detached for use as Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. After this certificate has been signed by 至 Diabetes Mellitus 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other'4 Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA Inpatient 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: d in by the f 5 Pending 1 Yes 2 No 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number August 27, 2010 O.C.M.E

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signat

ORIGINAL

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, L

Melissa Brassell, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11.15PM 201 4a. Facility Name (if not institution, and number) or Location of Death 4c. County of Death Himore utwillar If Under 1 Year If Under 24 Hrs 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔽 Months Days Hours Month, Day, Y Country) unk Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MI 1 Dives 2 D No mou 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1807 SUA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) une 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) JUOMICU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 1-to MOR 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21201 Approximate Interval Between Onser and Death shock, or heart failure. List only one cause on each line Due to for as a consequence of Due to lor as a consequence of Due to (or as a consequence of)

Ph_sician/ Medical Examiner

Department of Important: If it any injury or o

Physician/

Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

ould be filed within 72 hours after death with of Mental Hygiene. marked other than "natural", or items 23a matic event, the Medical Examiner must b

other traumatic .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma

Maryland 21215-0036

Baltimore.

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Hospital or Attending Physician; The law requires that the death certificate be executed

been

certificate has

After this

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A'

death.

Box 68760

P.O.

Records,

Division of Vital

20a. Method of Disposition 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that cau Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year,

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MATHOXE

Registrar

State

2835 SMITH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDILITT

31. Date filed (Month, Day, Year)

AUG 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27299 State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /25 JAMES ALBERT RICHARDSON-EL, JR. PM Medical Examiner 4b. City, Town, or Location of Deat 4c. County of Death timore 8. Dale of Birth (Month, Day, Year) May 19, 1949 5. Social Security Number 7. Age (In rs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. XX 2 F Hours Country) 61 Director 213-54-4900 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location illed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sh notified MD NA BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code è 10q. Citizen of What Country? g 23a Funeral must 2915 Parkwood Ave. 21217 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2X Married 1 ☐ Yes If Yes, Give 2x No 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 1 1/2 yrs Elementary/Seconday (0-12) ed other that: GED Carpenter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e HELEN JOHNSON JAMES ALBERT RICHARDSON-EL, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN RICHARDSON-EL -wife 21215 3605 Liberty Heights Ave. Balto., MD 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ON-SITE CREMATION CN. 8/31/2010 Baltimore, Maryland 4_a☐ Donation 5 ☐ Other (Specify) 21. So at e of Funeral Service License 22. Name and Address of Facility 4300 WABASH AVE. MARCH FUNERAL HOME WEST, INC. BALTO. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fulfure. List only one caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ed by the attending physician and detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide
Homicide Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29d, Datersigned (Month, Day, Year) 69

State Registrar Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 28, 2010 ar 6:25 A James Thomas Ramey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F 95 Months Days Hours Decementer 5, 1914 Tennessee B40-32-7667 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Marvland Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6817 Hillmead Road 20817 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛭 No Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Federal Government Atomic Energy Commissioner Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Drucille North James F. Ramey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1372 Masonic Avenue, San Francisco, California 94117 Drucilla Ramey/Daughter August 29, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery crematory or other place) Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01498 Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NUCONDULA disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No The law requires that the death Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) 10 1 🗌 Yes Other 2 1000 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of examination a large information and the strength occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ag 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Atul Rohatgi, M.D.,

31. Date filed (Month, Day, Year) AUG 3 1 2010

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. Registrar's Sign

8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death REDMAN Physician/ AUG BEVLAH EE 10:05 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗗 F Hours Min. 78 lo*2*76471932 519-30-4607 Director Montana Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Frederick 1 Yes 2 No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5648 Jacobs Court 21771 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting <u>Accountant</u> other traumatic event, Be be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ည John McKenna Beulah Lee Hendrix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5648 Jacobs Court Mt. Airy, MD Laurel Shuman - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 D Burial 2 Cremation 3 Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 08/30/2010 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Signature of Furieral Service Littens M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ection Winau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform hours after death.

uneral Director: After this certificate to the control of the 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) AUG 282010 29b. Signature and title of certifier phanla MDG1504 5955 Cedar &n Columbia, MD General Hospital Shanlas State Registrar

DHMH 17 Rev 7/2009

10-06489 Robert Frederick Rudloff, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
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		Registrar			Centitica	ne or	Deau					eg. No.			·-·
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Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	nday)	If Unde	er 1 Year s Days	If Under Hours	24Hrs. Min.			1	Foreigr	
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-003 I within giene. ther th	<u></u>	1.2 17. Father's Name (First, Middle,		2		Iv.	arın	e Med			irst, Middle, I	Maiden Sur		Oat	5
215. be filed ontal Hy rked of	Be C	Robert F.	Rudlof	f Sr.					Beti	-	Jane		one		
Should and Mer	၉	19a. Informant's Name/Relations Robert F. Rudlo		(fath	1.3						alRouteNum ∋na, MI			State,	Zip Code)
and 2 greath a tem 27 traum	- 1	20a. Method of Disposition			20b. Place o	f Dispos	ition (Nan	ne of ceme			Date			ity or T	own, State
more Pages 1 ent of F nt: If i		1 X Burial 2 Cremation 4 Donation 5 Other St		from State	Cedar	-	ner place) 1 Cei		У	Sept 2	. 01	Balt	timo	re,	Maryland
Saltil ermit. Pepartm mporta	Ì	21. Signature of Funeral Service	Lice see			1		Address o	-	St	alling				ome, P.A
Physician	+	23a Part I. Enter the disease, of	complications that	caused the	death. Do not	t enter th	ne mode d	Mount of dying, su	tain_ uch as car	Rd. rdiac or re	, Pasa	est, shock,	or hear	21	Approximate Interval
/Medical Examiner	İ	failure. List only one cause Immediate Cause (Final disease												Between Onset and Death	
<u> </u>	ł	or condition resulting in death)	Due to (or as	a conseque	nce of):										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a conseque	nce of):										
- Ti	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):					-					
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8760, tificate be exenge by the physician as the burial		IF FEMALE:		, outcome of								23d. D	ate of d	elivery	
687 certific nding p	jan/	23b. Was decedent pregnant in the past 12 months?	1	birth gnant at time			tal death	3	Ectopic	pregnanc	у	Mo	onth	Da	ay Year
Box 68 te death certi the attendin	Physicia	1 Yes 2 No 9 Uni	known =	nown	5	Oti	her (Spec								
P.O. B s that the d gned by the	P P	Part II. Other significant condit	tions contributing	to death but	not resulting	in the u	underlying	cause giv	en in Parl	t I.				_	ne cause of death? ably 4 Unknown
ds, F	ğ									_	24a. Was	an	24b. W	ere auto	opsy findings available
Records, The law require fificate has been si	Completed									_	autop perfo 1 ✓ Yes	rmed?	de	or to co ath? Yes	ompletion of cause of
tal Recting The certificate ector, page	မို မိ	25. Was case referred to medica						26.Place o		Check onl					
Vita		examiner? 1 ✓ Yes 2 No	Hospital: 1		2 FR/OU	_						Residence		Other:	
Division of Vital Isl or Attending Physician Is after death. The This certor: After this certified in by the funeral director.		27. Manner of Death 1 Natural 5 Pend	uirig	e of Injury th, Day, Year) 7, 2010	2006	ime of I hrs	njury	28c. Injury	s 2 XX	N.A.	3d. Describe l otorcycle				ct collision
visior or Attend or Attend or Attend or Attend in by the	Certification:		stigation 28e. Pla	ace of Injury	- At home, fa	rm, stree	et, factory	, office bui	ilding, etc.		or Town, S	State)			al Route Number, City
Diversitation of the points a point of the points of the p		4 Homicide			Road / Hig						/B Mountair	Road &			urt, Pasadena, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transi	Medical	(Check only 1 Certifying Plone) 2 Medical Exa	hysician: To the b miner: On the basi and manner	s of examina	owiedge, dea tion and/or in	in occur ivestigat	rea at the tion, in my	opinion, o	e and plac death occi	urred at th	ne time, date	and place,	and du	s state e to the	cause(s)
£.2 £ 8	₩	29b Signature and title of certific		Juliod.			290	. License							th, Day, Year)
		Warrente The	Shull					O.C.M	I.E.			Augus	1 28, 2	:010	
)		 Name and address of person Margarita Korell MD. 	who completed ca Assistant M		,	111 P	enn Str	eet, Bal	ltimore,	MD 21	201				
Sta	_	31. Date filed (Month, Day, Year)		Registrar's	ignature	M									
Registr	ar	AUG. 3 1 2010	A STATE OF		18										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 27303 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 27 Physician/ Month ZC/O SKENE ALEXANDER PM FUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GREENLOW ROAD BALTIMORE CATONSVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F April 12,1926 84 541-20-1678 Director Oregon Usual Residence of Decedent other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 349 Greenlow Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. X Yes 2 No 1943 Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 🎇 Divorced 1945 Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Mail Order Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Skene Annabelle Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 349 Greenlow Road Catonsville, Maryland 21228 Steven J. Skene, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 8/28/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NTERNAL HEMORRHAGE disease or condition CURS Medical resulting in death) Examiner COAGULOPATHY WEEKI Sequentially list conditions if any leading to immediate Examine to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events YEARS Hospital or Attending Physician; The law requires that the death certificate be executed HEPATIC CIRRHOSIS Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCITER ATRIAL FIBRILLATION, THROMBOCYTOPENIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MONOCLONAL GAMMPATH cate has l autopsy performe Yes 2 X No 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 ☐ Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 48261 05/2 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10753 FALLS RD SUITE 325 LUTHERVILLE MD 21093 32. Registrar's Signatur

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 27304 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vincent F. Serio 2010 2:13 Ρм August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Scotland Manor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Hours Min 102 Janth, 16 ^{Yea}1908 Maryland 218-01-8234 **Director** Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must b Funeral 21215 USA 2900 Boarman Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ≥ Maryland 21215-0036 hours after White 1 ☐ Yes 2 X No Specify. If Yes Give 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Die Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guiseppe Serio Mariannina Foraci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Catoctin Court 2B Frederick, Maryland 21702 Marlene A. Ward, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State ò 08/28/10 Metro Crematory Inc. Baltimore, Maryland any injury 4 Donation 5 Other (Specify) Signature of Funeral Service License Thomas Gregor Name and Address of Facility Of Maryland, Inc 9 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 1207 Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Month Day Year Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Lunkhown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performe 1 Tes 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred al or Attending P s after death. I Director: After t d in by the funera Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Hospital 24 hours Medica 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Willa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27305 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar_		Certific	cate of i	Death			Re	g. No.		
Physici		Decedent's Name (First, Midd				-			Date of Deat Month		ear	3. Time of Death
Medical Exam	iner	Christian St			1.45	City Town	.l. aantina		Month August 28			2259 hrs
		4a. Facility Name (if not institution Route 40 East at Hove			40	City, Town, or Catonsville	Location o			4c. County Baltimo	re Cou	inty
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last bi	rthday)	If Under 1 Year Months Day			3. Date of Birt	h(MM/DD/YYY	Y) 9. Bir Foreig	thplace (State or
Director		219-04-4075 Usual Residence of Decedent	1 M 2 F	37	Yrs.	Months Day	rs Hours	Wiin.	Dec 6	1972	Co	untry) Maryland
any		10a. State 10b. County		10c. City, Tow	n or Location	1						10d. Inside City Limits
<u>*</u>	_	Maryland N/	'A	Е	Baltim	ore						1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	/hat Cour	ntry?
the N 3a or 3	Dir	2309 Grove Str	eet			21	.230			US	Α	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decedent I Armed Forces?	Ever in U.S.		Decedent of His s, specify Cubar					e - Ameri te, etc.	can Indian, 8lack,
er dea:	Fur			X No		49-			, , , , , , ,			44.
irs aft iural"	þ	15. Decedent's Education (Spe	or Dates:	pleted) 16a		es 2X No		kind of work	c done	Specify: 16b. Kind of B		ite ndustry
72 hou n "na al Exa	etec	Elementary/Secondary (0-12)				t of working life						,
5-0036 led within 7' tygiene. other than	Completed	12			Labor	er				Const	ruct	ion
Filed v Hygi d other		17. Father's Name (First, Middle						,		laiden Surnam	e)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	Thomas A. Str 19a. Informant's Name/Relations		10	h Mailing A	address (Stree			Doughe		ım Stata	Zin Codo)
, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner.	٦	Thomas A. Strassno	, , , , ,	100		achwalk						Zip Gode/
e, N 1 and 1 and Health item		20a. Method of Disposition	-	20b. Place		on (Name of ce			ate	20c. Location		Town, State
MOF Pages ent of nt: If		1 Burial 2 X Cremation 4 Donation 5 Other S		10		atory I	nc.	08/30)/10	Ralti	more	, Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		21. Signature of Funeral Service	Thomas (Gregor	22 Nar Cre	me and Address	of Facility	tv Of	Marvl	and. I	nc.	nd 21228
		Chomus X	Duy	h. d. th. D.	299	Freder	ick I	Road I	Baltimo	ore, Ma	ryla	nd 21228
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			, .				st, snock, of ne	eart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Drowning Due to (or as a consec		cating	Multi	le I	njuri	es			Death
		Sequentially list conditions,	b	1							8	
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):								
	Examine	(Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):								
cecuted and transit			d	27 20	. С		07.0	12 1	0			
760, cate be exe physician the burial -	/Medical	X UNPENDED	AMENDED 23a	323		r me g	907 9	-13-1	U VE			
8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome			death 3	Ectopic	pregnancy		23d. Date o Month	,	ay Year
Box 68's death certification at for use as it	Physician	past 12 months?	4 Pregnant at ti		- =	(Specify)				1		
BO) he deatl the att hed for	چُ		known 9 Unknown	had a decident					District	1	-1	harana af da atho
of Vital Records, P.O. E ng Physician: The law requires that the d After this certificate has been signed by the neral director, page 2 should be detached	اھ	Part II. Other significant condit	ions contributing to death	but not resultir	ig in the und	ieriying cause g	jiven in Pai	π1.				he cause of death? ably 4 Unknown
ords, F w requires to s been sign should be o	ted		-		-			- /	24a. Was ai			opsy findings available
COT law re has be	Completed								autops perforn	y		ompletion of cause of
tal Rec		OF Mos area referred to medica					-6 D11- /	Ob l l -	1 ✓ Yes 2	No 1	✓ Yes	s 2 No
Vital hysician: this certif	Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatien	t 2 FR/C	outpatient 3		Other	Check only		lesidence 6	Other	Scene
of V ing Phy After th	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	y 28b.	Time of Inju		y at Work?			w injury occur		-
ion of tending Pheath.	tior	1 Natural 5 Pend			10:40)pm 1 1	es 2 🗶	No S	ubiect	iumped	l fro	om bridge
Division pital or Attendit ours after death. reral Director: /	Certification:	. =	stigation 28e. Place of Inju	ıry - At home, f	arm, street,	factory, office b	uilding, etc					al Route Number, City
Divis Hospital or At 24 hours after d Funeral Direct	Se	4 Homicide	rmined (Specify) on	rocks	by ed	ge of r	iver	Co	Line	Cato	nsvi	lle, Md.
	Medical	10000000	hysician: To the best of my miner:On the basis of exam	_								
To the within To the comple	Med	29b. Signature and title of certifie	and manner stated.			29c. Licens				29d. Date sign		
		/ Calala	110			O.C.I				August 29		
	ŀ	30 Name and address of person	who completed cause of de	ath (Item 23a)					J			
<u></u>			ssistant Medical Exar	miner 11	1 Penn S	treet, Baltin	nore, Mi	21201				
		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	are	,						
Regist	raiï	AUG 3 1 201	IU John	19.19	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death t's Name (First, Middle, Last) te of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Deasons Hospice - NW Hospital Baltimore andallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 XF (Month, Day, 169.22.0339 Country) Director MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Pikesville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21208 Rockvidge 20ad Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12H1 Grade College (1-4 or 5+) State of Maryland Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ived Harris Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON Street Demis Pulaski 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 09/07/ 10 Owings Mills, MD 4 Donation 5 Other (Specify) arrison 21. Signature of Funeral 22. Name and Address of Facility augno C. Greene Funeral Services Randall stown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tyes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner

attending physician a for use as the burial-

Be

ပ

Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760

28a-f show

Б

must be notified at

should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho:

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, any injury or other traumatic event, the Medical Examiner must be

Baltimore, Maryland 21215-0036

24a. Was an autopsy performed'

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 28d. Describe how injury occurred 28c. Injury at

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier

28a. Date of injury (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

30. Name and

31. Date filed (Month, Day, Year)

State Registrar

25. Was case referred to medical

2 No

5 \square Pending

Investigation

6 Could not be

examiner?

1 Yes

27. Manner of Death

1 Natural

only one)

29b. Signature and title of certifier

within 24 hours after des To the Funeral Directon completed filled in by th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 27307 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 7 Year 2 010 AUGYIT Physician/ 04:15 PM Rudolph Small Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown <u>Season's Hospice</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 08 2-56-3871 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 √ Yes 2 □ No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21201 U.S.A. 607 Pennsylvania Ave Apt 102 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 0. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filled within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 2 & E Contractors Loan Officer 2th grade lyr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Small Geneva Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pembroke Ave, Baltimore, Md 21206 Paula Small-Sister Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B/25/2010 On-Site Baltimore, Md gnature of Funeral Service License 22. Name and Address of Facility March F/H West nomiosin 4300 Wabash Ave, Baltimore, 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer-Mysepitheoral Physician/ Medical Due to (or a consequence of): Examiner Sequentially list conditions, Examine fany leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ned by the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Į Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 24 hours after death. Funeral Director; A 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director; and completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Who Bled 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

GLA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,1\,0$ State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 25 M Smith Jr. 2010 Medical Ernis റമ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 02. 03 Year Country) 1 XM 2 - F SC Director 213-39-5162 43 67 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Martinal. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 No Baltimore NA MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 U.S.A. 1701 Eutaw Place Apt Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dmadma Company 10th grade Machine Operator na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maybel Smith Ernis Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terra Firma Road, Baltimore, Md 21225 Smith-Daughter Kista 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Baltimore, 8/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Baltimore, 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final concer Physician/ LUN CEVI Small disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) director, Hospital: Other: မ 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) WSALG 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours and he Funeral Director; Af 2 Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sign

29c. License number

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29d. Date signed (Month, Day, Year)

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10-06467 Inetha Sheppard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certii	ficate of	Death				Reg. No	D .		
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Medical Examin	er	InethaShepp		mbor)		T AL	o. City, Town,	or I cont	ion of Dogs	August	26, 20	10	f Dooth	1800 hrs
		4a. Facility Name (if not institution 6026 Amberwood Ro	ad .				Baltimore					kc. County o	A	
Funeral Director		5. Social Security Number 214–19–9128	6. Sex	7. Age (I	n yrs. last 35	birthday) Yrs.	If Under 1 Ye Months Da	_	Jnder 24Hr ours Min			M/DD/YYYY		thplace (State or in MD untry)
iow any		10a. State 10b. County MD N/A		10		own or Location				······································				10d. Inside City Limits 1 X Yes 2 No
ne Maryland or 28a-f show fied at once.		l 10e. Street and Number 606026 Ambert	wood Roa	d d			10f. Zip Code	120	6		10g. Ci	tizen of Wh	at Cour	
s after death with 1 trap", or items 23, uiner must be not	by Funeral		arried 12. Was Dec Armed F 1 Yes vorced If Yes, Give Yes or Dates;	orces? 2 X	No	If Yes	s, specify Cuba es 2 N	an, Mexi lo <i>sp</i> ec	can, Puerto			Afri	k car Lcar Amer	rican
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MD 2 nd 2 shoul alth and M en 27 is m		19a. Informant's Name/Relations Allen Branch 20a. Method of Disposition	n/Son			19b. Mailing A 2723	Calve	rt	st.,	Balt.	, MD	2121	8	Zip Code) Town, State
altimore, mit. Pages l ar partment of Hee portant: If itee ury or other tr		1 Burial 2 Cremation 4 Donation 5 Other S	pecify:	om State	Bayv	watory or othe	rem.			0 / 1 0	Ba	altim	nore	e,MD
		21. Signature of Funera Service	-							ri P. Balt.				
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State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20 10

		1	For State Registrar				,	Ce	rtificate of	Dea	th		Reg. No.				
			1. Decedent's Name (First, Midd	fle, Las	t)							2. Date of De Month		, -	Year_		of Death
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DHMH 17 Rev 1/2001

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Ь.	Director		213-14-3841 Usual Residence of Decedent	I C W Z X F		89 Yrs.				(Month, Da June 0	5 19	921	Oddrit	" MD	
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ary.	ould Ind Me		19a. Informant's Name/Relation			19h Mailir	na Address (Stre	et and Nu		ral Route Numbe			Zio C	ode)	
	d2shaltha altha 127is ertrae		Rosemary Gray	(daught	er)	1					-		-	E. 19975	
altimore,	of He of He if item r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demond from State			sition (Name of natory or other p	olace)	7)	Date	20c. l	Location - City	y or To	wn, State	
<u>ä</u>	. Раде tment tant:		4 Donation 5 Other		-	, .	ark Cem	,		. 30 010	Bal	timore	, M	aryland	
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service	Licensele	,	22	Name and Ad	dress of Fa Dunta	acility S .in Ro	talling: ad, Pas	s Fu aden	neral	Hom 211	e, P.A. 22	
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Division of Vital Records,	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Coul- 4 ☐ Homicide deter	mined 28e, Place of Ir	njury - At ho etc. (Specify		eet, factory, office	ce		28f. Location (City or To			Rurai	Route Number,	
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	To the Hospital or Attending Phywithin 24 hours affer death. To the Funeral Director: Affer this completed filled in by the funeral d	Medical	(Che) Me cal	ng Physician: To the best of Examiner: On the basis of	examination	n and/or inves	tigation, in my or	oinion, dea	th occurred :	at the time, date	and plac	e, and due to	the cau	se(s) and manner s	stated
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7			monit was	n 555 Sau	th Ce	uters	otreet (190	stmil	ster it	10 5	1001			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ August 29, 2010 5:26 AM John Paul Trovato Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care - Canton Harbor Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) ec. 14. Months Baltimore, 1**X** M 2 □ 95 Director 216-32-9933 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Baltimore 1 🕅 Yes 2 🗌 No MD Baltimore City 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 209 South High Street 21202 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WWII other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Grocery Store Grocery Store Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Canizzaro Concetta Orazio Trovato permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Dolores T. Call / Niece Glen Burnie, MD 203 1st Avenue SW, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 9/1/2010 | Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW, Glen Burnie, MD 21061 • M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jeumonia Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confinence. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral work? 1 Yes 2 No iniury Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗌 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

341

State Registrar 31. Date filed (/

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27314 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Year 2010 70000 2330 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOMICO REGIONAL MEDICAL SALISBURI If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 17 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director Perc 1 Yes 2 No 10e. Street and Number items 23a or 10f. Zie Code 10g. Citizen of What Country? Funeral chaelsvil Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည rances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 2.... Department of Health an Important: If item 27 is " iniury or other tra pretty Perryman Michaelsville Rd 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Datework cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 → Donation 5 ☐ Other (Specify) 21. Signature Service Licent 22. Name and Address Lility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Melastalic Co Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine to (or as a consequence of) if any leading to invend to cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown 5 Other (specify) 2 No g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 2 N 2 🗌 No Yes or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 X No Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. 1 Natural 5 Pending injury 2 🖵 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 2010 D63199

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year,

CARROLL ST.

SAlisbury

21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:47 Am Hariam Tave 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of. Health Montgomery National Institutes Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🗓 F Months Days Hours Min. Year) Director 464-29-7354 43 1966 Ethiopia Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Arlington **Arlington** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1410 Patrick Henry Drive 22205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hailemariam Taye Woldesemayat Aska1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrace Court Apt#1543 Alexandria VA 22302 Girma Besufekad/Brother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08-27-2010 Silver Spring, MD Gate of Heaven 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Marshall March Funeral Home 4217 9th Street N.W. Washington,DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MONTUS 23a, Pat ck, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Inrombotic Microaugiopatuu / Medical resulting in death) Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🛮 No 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 XNo မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 No ☐ Accident Investigation Director: 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

HMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

AUG 3 1 2010 Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

Michael Eberlein

MD PUD

Eberlein

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D64823

Bethesda.

29d. Date signed (Month, Day, Year) 08/24/2010

20892

MD

29c. License number

10 Center Drive.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27316 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Geraldine 19:40^M Thompson 08 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 KF Days Hours Min. (Month, Day, Year) 09-18-1935 Country) Director DC 579-46-7363 74 Usual Residence of Decedent show 10a, State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sl 1X Yes 2 □ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 12325 New Hampshire Avenue 20904 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give "natural" 3 Widowed 4 X Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 Pof Health and Mental Hygiene. Item 27 is marked other than "nother traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 vears Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Davis Beatrice Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela T. Walker/Daughter item 27 White Oak Vista Ct. Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State <u>__</u> Department of Important: If i any injury or or 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 08/30/2010 |Suitland, MD 22. Name and Address of Facility . Si mature of Funeral Service Licenses Marshall March Funeral Home 4217 9th Street N.W. Washington, DC 20011 At 1. Earlier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysician/ disease or condition Myocardial Infarction Acute Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions Examiner than heading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a c ODBIG DISTORY by the attending physician and stached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Day Year signed by the at d be detached for 1 ☐ Yes ≥ y g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Gastro-Intestinal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 K No certificate 1 Yes 2 No eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🕅 No Other: 1 🗌 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ypta D-32332 08/25/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Suresh K.

31. Date filed (Month, Day, Year)

AUG 3 1 2010

Gupta MD

9801 Georgia Ave. Ste 2-20 Silver Spring MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year MES 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore lanor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 217-12-8008 Hours 1 MM 2□ F Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner trans be notified at MD Director 1 No 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21215 Avenue, USA ітетя 23а Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify Blac 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. If item 27 is marked other than 2+1 17. Father's Name (First, Middle, Last) Be Maiden Sumame, 8 lames 19b. Mailing Address (Street and Number or Rural State, Zip Code) Pages 1 and 2 30 252 20b. Place of Disposition cometery, crematory 20a. Method of Disposition permit. Pages Department of h 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State Important: any injury o ^¹ 4 □ Donation 5 ☐ Other (Specify) oreen 21. Signature of Funeral Service L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** CHRUNIC PULMONARY OBSTRUCTIVE /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of). death certificate be executed resulting in death) Last burial-1 Due to (or as a consequence of) P.O. Box 68760. physician use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, should be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown been : ARTERY DISGAS 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No has N page this certificate 1 🗌 Yes 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural trijury 5 Pending investigation death. 1 🗌 Yes 2 🗆 No after death Director: / 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D D003 -27-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS RE159 Mo 21136 DRIVE 32. Registrar's Si State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Jane Wong 2ď†o August 8:50 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 216-56-4418 1 M 2XX Months Days Balt. Maryland Director 61 December 18, 1948 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States Funeral 20 Haddington Road 21093 of America 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Chinese 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working e 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than " or other traumatic event, the Mes Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Wong Jane Lee 19a. Informant's Name/Relationship (Type, Print)
Personal
Joannes Toledo/Representative 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Londonderry Road Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or of ₹ September 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 1, 2010 Timonium, Maryland Memori Gardens Signatu ral Service Lie Peaceful Alternatives Funera and Cremation Ctr.,P. 2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ANCON disease or condition Medical resulting in death) Due to (or as a o sequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မြ 01ce After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specification of the Control of the Co 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Natural Accident
Suicide work' neral Director: A filled in by the fi Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number uno 25200 death (Item 23a) (Type, Print) and address of person who completed cause of Charles St. 6701

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 110 5:17 AM Medical 140 4a. Facility Name (if not institution, give street and number) Examiner 4b. Çity, Town, or Location of Death 4c. County of Death General Howard umbia Md Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 6, **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Min. Country Virginia 1932 Director Yrs. 212-30-4530 78 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore City Baltimore** 1 ☐ Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 72 hours after death with 656 Charraway Road U.S.A. 21229 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 xMarried Baltimore, Maryland 21215-0036 than "natural", If Yes Give 1 Yes 2 XNo Specify Black 3 Widowed 4 Divorced Specify Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other tha Social Security Administration File Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ John H. Jones Sr. Lillie F. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alphonso Walker 656 Charraway Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or cemetery, crematory or other place) 09/03/10 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Park Cemetery 21. Signature d 5 meral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P 300 Eutaw Place Baltimore, Md 2 art 1. Enter the disease, or complications that caused hock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ disease or condition resulting in death) Medical Due to (or Examiner hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ancer Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1' Natural (Month, Day, Year) 5 \square Pending 1 Tes Accident 2 No Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29d, Date signed (Month, Day Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter 32. Registrat's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Arvid Wennerberg Leroy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Cente Glen Burnie Anne Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Montana 1 🕅 M 2 🗆 F Months Hours Min. (Month, Day, Year) 05/26/1923 Director 212-20-1819 Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 566 Pasture Brook Road U.S.A. 21144 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>6</u> 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3√ Widowed 4 □ Divorced Completed Specify: White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trust Officer Finance / Insurance permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tit once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Wennerberg Nina Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan Franklin / Daughter 566 Pasture Brook Road Severn, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 □ Donation 5 ♥ Other (Specify Entombment Crestlawn Mem. Gard. 08/30/2010 Marriottsville, MD 22. Name and Address of Facility 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Encephalopathy Physician/ Anoxic disease or condition Medical resulting in death) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami ig physician and as the burial-transit VALVULAR HEART that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulu monia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work' Accident Investigation 1 🗌 Yes 2 🗆 No 3 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 47575 August 25, 2010 cause of death (Item 23a) (Type, Print)
D. 305 Hospital Dr. Ste 305. Glen Burnie, MD 21061 MATTHEW PARK, M.D.

Registrar

State

31. Date filed (Month, Day, Year)

WENNERBERG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State of Maryland / Department of Heat Certificate of Death	oth 2010 / 1371
	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician/ Medical	Anna J Wise	August 29, 2010 4:30 AM
Examiner		
	Glen Burnie Health and Rehab. Center Glen Bur 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 1 if 1	
Funeral Director	¥ 1	Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Oct 23, 1925
	Usual Residence of Decedent	
yland f she ed at	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
or 28a-f sho notified at	MD Baltimore City Baltimore	1 🛱 Yes 2 □ No
th the	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death with the items 23a construction and the must be Funeral	3019 Royston Avenue 212	
r dea	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Ves 2 □ Married	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
336 safter of all", or i		
5-0 hours natur lical	15. Decedent's Education 16a. Decedent's Usual Occupation	
21215-003 within 72 hours a liene. In than "natural" the Medical Ext	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)	g most of working
e C the transfer of the transf	12 yrs. Homemaker	Own Home
land 2 be filed w ental Hyg ked othe c event,	10.	Mother's Name (First, Middle, Maiden Sumame)
Yla Vla be I Men narke narke	Toopin Dimenselley Billy Mariewick	Regina Zaremba
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by	17.	lumber or Rural Route Number, City or Town, State, Zip Code)
and 2	Mrs. Karen Uhlik / Niece 3019 Royston A 20a. Method of Disposition (Name of	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 🗆 Burial XX Cremation 3 🗆 Removal from State cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Iltir	4 □ Donation 5 □ Other (Specify) Atlantic Crematory 21. Signature of Euneral Service Ligensee	08/31/2010 Glen Burnie, Maryland
Bal permi Depar Impor		Facility Singleton Funeral & Cremation 1 2nd Ave SW, Glen Burnie,MD 21061
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, sur	
enysician/	shock, or heart failure. List only one cause once ch line. Immediate Cause (Final	Interval Between Onseifand Death
Medical	disease or condition resulting in death) a. Due to (or as a consequence of):	- any (
Examiner	Acute Kenul Laile	ul 3 annie
kecuted and al-transit	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	1000
cutec transi	that initiated events c.	use 10 years
cian cian	resulting in death) Last Due to (or as a consequence of):	/
certificate be executed nding physician and use as the burial-transit	d	
O. Box 68 tt the death certifit I by the attending stached for use as Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Old Data of delivery
box death c death c he atten ed for u	in the past 12 mopris? 1 Ves 2 No 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
tr the d	g □ Unknown 9 □ Unknown	
Hecords, P.O. The law requires that the rate has been signed by the page 2 should be detach.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	
dS, duire quire ould to ould the		1 Yes 2 🖽 3 🗆 Probably 4 🗆 Unknown
VItal Kecords, vsician: The law requires is certificate has been sig director, page 2 should b		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
The The Page		performed? death? 1 Yes 2 Yes 2 Yes 2 Yes 2
cian: certific ector,	examiner?	Death (Check only one)
Physi this c al dire	1 Inpatient 2 ER/Outpatient 3 DOA Otter 4	Uvursing Home 5 Residence 6 Other (Specify)
or Attending Plafer death. Director: After thin by the funeral in by the funeral	1 Natural 5 Pending (Month, Day, Year) injury work?	28d. Describe how injury occurred
SIO Atten r deat ctor; y the	3 Usuicide 6 Could not be	28f. Location (Street and Number or Rural Route Number,
DIVISION all or Attendir s after death. Il Director: After in by the fur	4 Lightharpoonup determined determined building, etc. (Specify)	City or Town, State)
DIVISION OT VITAI RECORDS, P.O. BOX 68 7 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as Medical Certificate: To Be Completed by Physician/Me	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date	and place, and due to the cause(s) and manner as stated.
the H nin 24 the Fi nplete	only one) 3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, dea	ath occurred at the time, date and place, and due to the cause(s) and manner stated.
To will	29b. Signature and title of certifier 29c. License num	ber 29d. Date signed (Month, Play, Year)
	Levy svy m DI	08/30/10
H	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Park Druse Was Buch ind
State	31. Date filed (Month, Day Year)	1 + 1001 0 00 13 01 011, alog
Registrar	AUG 3 1 2010 AUG 3 1 2010 Aug Segistratis Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011

		- For	State of Marylar		artment of Health a			0 27322
		State Registrar		•	rtificate of Death	,	Reg. No.	
Physic	cian/ dical	1. Decedent's Name (First, Middle, L	_{ast)} berta Finney A	tkinso	N	2. Date of De Month Augu	Day Ye.	3. Time of Death
Exan		4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or Location of		4c. County of D	
F		11409 Columbia 5. Social Security Number 6.	Pike, #C5 Sex 7. Age (In yrs.	loot hinth do. d	Silver S			ntgomery
Funera Directo	_	226-54-3269 Usual Residence of Decedent	1 □ M 2 🗓 F 7. Age (iii yis.		Months Days Hours		g. (7/1940	Birthplace (State or Foreign Country) Virginia
ING 21215-0036 if filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland Montg		ity, Town or Lo		r Spring		10d. Inside City Limits 1 🔲 Yes 2 🔀 No
hthe M taor 2 be no		10e. Street and Number			10f. Zip Code	c Spreeng	10g. Citizen of What	
tth witl ms 23 must	nerg	11409 Columbia			20904			u.s.A.
36 after dea ", or ite aminer	र्व	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	į i	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I ☐ Yes 2 🏿 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, W	
-00; lours a attural cal Ex	eted	3 ☐ Widowed 4 🗶 Divorced	Year or Dates.				Specify: A	rican-America
21215-0036 within 72 hours after giene. er than "natural", o	Completed	(Specify only highest g	grade completed)	(Give I	lent's Usual Occupation kind of work done during most o D NOT use retired)	of working	16b. Kind of Busine	ess Industry
d withi	Be Co		College (1-4 or 5+) 5 +		Teacher		Edu	cation
lanc be file lental H rked of	I B	17. Father's Name (First, Middle, Last)	Alvin Finney		18. Mother	s Name (First, Middle,	^{Maiden Sumame)} Mina Porte	
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street and Number of			
		Glenda C. Atkins	on - Daughter		Battersea Plac			
Oo≗≃≽	ı	20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date	20c. Location - City	or Town, State
baltim permit. Pag Department Important: any injury o	51	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licer	Ft.	Linco	Ln Crematory 0 Name and Address of Facility	8/18/2010	Brentwood,	Maryland
any per de de de de de de de de de de de de de		South	MO1894	11	800 New Hampsh	ire Ave	Silver Spr	ing. MD 20904
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	iplications that caused the deat one cause on each line.					Approximate Interval Between
Physician Medica		Immediate Cause (Final disease or condition resulting in death)			Accident			Onset and Death 2 Weeks
Examine	_		Due to (or as a consequence of the state of	- /-	un Canaah			11 40 544
Q = ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ		n cancel			1½ years
be executed sician and burial-transi	cal Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	lenco off:				34
e be executed spician and le burial-transit	ical	looding in doubly East	d	derice oi).				
ertificate ding phy se as the		IF FEMALE:	d					
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of of	aldeath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year
that the led by detac	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
requires in the second period	ed b	Cerebrov	ascular Diseas	e		1 🗆 Y	/es 2 🗓 No 3 🗆	Probably 4 - Unknown
aw rec as bee	Completed					24a. Was a		autopsy findings available o completion of cause of
: The licate h						perfor	med? death	
sician s certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		26. Place of Death (
ng Phy ter this		27. Manner of Death	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury at		ence 6 Other (Spe ow injury occurred	ecify)
tendir Jeath. Por; Af the fu	Certificate:	1	n	injury	M 1 ☐ Yes 2 ☐ No			
tal or At is after of al Direct ed in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office	28f. Location (St City or Town	treet and Number or R n, State)	Rural Route Number,
e Hospi n 24 hou e Funer	Medical	(Crieck 2 in Medical Exami	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or investic	ration, in my opinion, death occur	red at the time date an	d place and due to the	a cause(s) and manner stated
		29b. Signature and title of certifier	2 Tractioner, to the best of thy	Knowledge, de	29c. License number		cause(s) and manner a 29d. Date signed (Mon	
13		Final M	Junelling		D35996		August	16, 2010
-		30. Name and address of person who	mpleted cause of death (Item	23a) (Type, Pri	nt)			10
Sta	ite	Linda Burrell, N 31. Date filed (Month, Day, Year) AUG 17 2010	32. Registrar's Signati	sity B	kva., #400, Wh	eaton, Mar	ykand 2090	172
Registr		AUG 17 2010	Reneral A.	Back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27323 Edmund Etien Allain State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day August 12, 2010 Year Medical Examiner Edmund Etien Allain 1539 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or Foreign Washington 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 578-92-2204 Country) 1X M 2 F 12/01/1971 38 D. C. Usual Residence of Decedent 'n 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Prince George's Hyattsville 1 X Yes 2 No Maryland items 23a or 28a-f shoust be notified at once. with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20781 3827 Hamilton Street, Apartment 201 S. A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes Divorced If Yes, Give Year Yes 2 X No specify. Specify: Black "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I.T. Technology permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. than and Consulting Computer Programer If item 27 is marked other 17. Father's Name (First_Middle_Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Marsyl Vivian L. Washington Maurice Joseph Allain 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 3827 Hamilton St., Apt. 201, Hyattsville, MD 20781 Loretta A. Allain/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X 8urial 2 Cremation 3 Removal from State mportant: 8/20/2010 Brentwood, Maryland Donation 5 Other Specify Lincoln Cemetery H 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home, Road, Bowie, Maryland <u>Annapolis</u> Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o δ. ۵. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA 1 Yes After 1 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Bicyclist struck by auto Natural FOUND: 1 Yes 2 V No within 24 hours after death. To the Funeral Director: Director: d in by the f Pending Aug 12, 2010 1526 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) E/B Powder Mill Road west of Rt 197, Bowie, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2010 30. Name and address of person who completed cause of death (Item 23a) 8 Deputy Chief Medical Examiner Jack Titus MD. 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

AUG

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUG ARNOLD GENEVA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Pay, 1 □ M 2 🕱 F Days Hours Min Director 88 415-26-4588 Oct. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Clinton MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 4309 Broken Arrow Ct. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wn. -+al Hygiene. - or than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene 4 yrs Teacher Be 17. Father's Name (First, Middle, Last) မ unknown Mary Frank Wilson 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Marilyn Thompson - Daughter 4309 Broken Arrow Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 8-18-2010 21. Signature of Euneral Service Licenses Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) CAMMIA Medical Due to (or as a consequence of): **Examiner** DOGODOLA Sequentially list conditions. Examine any, leaving to immediate cause. Enter Underlying Cause (Disease or ilnjury Due to lur as a consequence of: CONONAM that initiated events Due to (or as a consequence of) tending physician ar rr use as the burial-t resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an has performed? Yes 2 No Hospital or Attending Physician: The certificate 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 2 1 🗌 Yes 1 ☐ Inpatient 2 FER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Accident 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Check only one) 29b. Signature an title of certifier 29c. License number

Calvert County Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, Md. 20c. Location - City or Town, State 22. Name and Address of Facility
Marshall's Funeral Home of Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0041580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Rd. Clinton, MD. Kelso Scott, MD 31. Date filed (Month, Day, Year) 32. Registrar' State AUG 1 8 2010 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

27324

19:43 p^M

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2X No

2010

Black, White, etc.

Black

			For State of Maryland / Dep	partment of Health and ertificate of Death			27225
			Registrar 1. Decedent's Name (First, Middle, Last)	erillicate of Death	2. Date of Death	g. No. 2010	3. Time of Death
	Physicia Medic		Mary H. Anderson		Month August		8:40 P M
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Death	
	Funeral		St. Thomas More Medical Complex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Hyattsvi If Under 1 Year If Under 24 Hrs			George's
ŧ	Director		577-34-0168 1 □ M 2 🖾 F 83 Yrs.	Months Days Hours Min.	June 24,	1927 Car	faryland
	and show	٥	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl 28a-f otifiec	irect	DC	Was	hington		1 ☒ Yes 2 ☐ No
	ith the 23a or at be n	밀	10e. Street and Number 528 46th Street SE # 2	10f. Zip Code	10	g. Citizen of What Cou	*
	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	20019 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	United	d States
36	after d I", or i	þ	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify:	o Rican, etc.)	Black, White	
9	hours a natura ical Ex	Completed	3 LA Widowed 4 Li Divorced Year or Dates. 15. Decedent's Education 16a Dece	edent's Usual Occupation		Specify: Ame	rican
215	nin 72 ne. han "r e Med	ошо	(Specify only nignest grade completed) (Give	e kind of work dane during most of wo DO NOT use retired)	rking	6b. Kind of Business I	ndustry
d 21	ed with Hygier Sther t	Be C	12th Sc	hool Bus Attendan		Governm	nent
lan		2	The autor of Harris (1 1/15), Innualis, Easty	unknown 18. Mother's Nai	me (First, Middle, Ma.	iden Surname)	unknown
Maryland 21215-0036	sh au si	1		ing Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip	
è,	and 2: Health tem 27	1	Eugenia P. Henderson/ Niece 528 20a. Method of Disposition 20b. Place of Disp	46th Street SE #2			019
E E	Page 1 nent of int: If ii		1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State	ematory or other place) Aug	ust 17,	Oc. Location - City or T	
Baltimore,	permit. Page 1 and 2: Department of Health Important: if item 27 any injury or other tr		Al Elicon		<u> </u>	Suitland, neral Home	
		H	23a. Part Enter the disease, or complications that caused the death. Do not enter the disease of complications that caused the death.	4001 Benning Road	NE Washir	ngton, DC	20019
7	Ph_sician/		I be stick, or near tallure. List only one cause on each line.	ic Heart Disease	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) ARTERIOSCLEROTS Due to (or as a consequence of):	te heart bisease			years
		ē	Sequentially list conditions, if any, leading to immediate b.				
	uted d ansit	amir	Cause. Enter Underfying Cause (Disease or iinjury that initiated events C.				
	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last Due to (or as a consequence of):				
/60	cate b physic s the b		d				
80 X	ending use as	au/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3	Fotonia nyaznana.		23d. Date of deliv	very
X P Q	the att	Physician/M		Other (specify)		Month	Day Year
J.	requires that the death certific been signed by the attending p should be detached for use as	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ds,	quires en sign	ed b	Dementia		1 🗆 Yes	2 □ No 3 □ Pro	bably 4 🔼 Unknown
CO	law re has be e 2 sho	Completed			24a. Was an autopsy	prior to co	psy findings available empletion of cause of
VItal Records,	n: The ificate or, pag		25. Was case referred to medical		performed		2 🗌 No
VITA	nysicia iis cert direct	lo Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Chec		e 6 Other (Specify	4)
DIVISION OF	ing Pt		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury (Month, Day, Year) injury	28c. Injury at work?	28d. Describe how in		
200	Attence r death	ertificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury. At home, farm, str.	M 1 ☐ Yes 2 ☐ No	28f Location (Street	t and Number or Rural	I Pouto Number
2	ital or urs afte ral Dire	၁၂	building, etc. (Specify)		City or Town, Si	tate)	
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director.	Medical	29a. Certifier (Check (tidation in my opinion death occurred a	t tha time data and al	lane and due to the one	
	To the within To the compl		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, of 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	ce, and due to the cau	use(s) and manner as sta Date signed (Month, L	ated.
			I tallen Wood	D01852	Au	gust 13, 2	2010
R	3	(30. Name and address of person who completed cause of death (Item 23a) (Type, F Paul A. Devore 4203 Queensbury Road		. 20781		
	State		31. Date filed (Month, Day, Year) 32. Register's Signature	myactsville, M	20/01		
	Registra		AUG 1 8 2010 Cenus S. Marke				

10-06401 Lisa Brummitt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 27326

		1- For State Registrar			Certific	ate of	Death			F	Reg. No.		
Physici Medical Exam		Decedent's Name (First, Midd	le,Last) ATHER	BF	RUMMI	TT				2. Date of De Month August 2	Day `	/ear	3. Time of Death 1131 hrs
		4a. Facility Name (if not institution 11891 Knoll Crest	on, give street and n	umber)		41	o. City, Town, La Plata	or Location	of Death		4c. Cour Charle	ty of Deat	h
Funeral Director		5. Social Security Number 521 – 08 – 6778	6. Sex		yrs. last birt	thday) Yrs.	If Under 1 Your Months Da	ear If Un ays Hou	der 24Hrs. rs Min.		irth (MM/DD/YY	Forei	irthplace (State or ign MTORADO
any		Usual Residence of Decedent 10a. State 10b. County		10c	City, Town	or Locatio	n						10d. Inside City Limits
daryland 28a-f show 1 at once.	ctor	MD CHAR 10e. Street and Number	LES		LA P	LATA	10f. Zip Code				10g. Citizen of	What Co.	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once,	l Director	11891 KNOLL	CREST LA	ANE			206					S. A	•
r death w	Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	arried 12. Was Dec Armed F 1 Yes orced If Yes, Give Yes	orces?		If Ye	Decedent of His, specify Cub.	an, Mexica	n, Puerto R			nite, etc.	rican Indian, Black,
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates:	de complet		Decedent's	s Usual Occup st of working li	ation (Give	e kind of wo		16b. Kind of	WH	
0036 within 72 iene. er than '	Completed		4	1-4 OI 3+)	CE	RTIF	IED N				HOSP		
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, WILLIAM AL	AN SUTTO	N					•		Maiden Surnar NN BIS	,	
timore, MD 21215 1. Pages I and 2 should be file truent of Health and Mental Hy rtant: If item 27 is marked o y or other traumatic event, th	To	19a. Informant's Name/Relations MICHAEL BRUM		JSE							mber, City or T		e, Zip Code) MD 20646
		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr	om State	20b. Place o cremate	of Dispositi ory or othe	on (Name of c r place)	emetery,	AUC	Date 3.26,	20c. Locatio	n - City or	Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other SA 21 Signature of Funeral Service		$\overline{}$	ATLA		CREMA me and Addre			10 10ND I	GLEN FUNL.	BUF SERV	RNIE, MD
		23a. Part I. Enter the disease, or	7 200) M	10064	1 56	35 WAS	SHIN	GTON	AVE.	LA PL	ATA,	MD 20646
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease	on each line.				e Intox	-		espiratory an	rest, snock, or i	iean	Approximate Interval Between Onset and Death
and the second		or condition resulting in death) Sequentially list conditions,	Due to (or as a	,									
- 34 - 76	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a										
ecuted and transit	- 1	events resulting in death) Last	Due to (or as a	·	,								
8760, ificate be executed g physician and st the burial - transi		X UNPENDED IF FEMALE:	23c. If yes,			n-f p	er me g	g907	9-8-10) vt	23d. Date	of deliver	<u> </u>
	Physician/	23b. Was decedent pregnant in the past 12 months?1 Yes 2 ✓ No 9 Unk	I Live b	ant at time			death 3 r (Specify)	Ectop	ic pregnanc	y	Month		Day Year
ires that the d signed by the	by Phy	Part II. Other significant conditi			not resulting	in the und	lerlying cause	given in P	art I.				the cause of death?
rds, Frequires	ompleted									24a. Was	an 24b	Were au	topsy findings available
Records, The law require ficate has been si	Comp										rmed?	death?	completion of cause of
ital Redician: The scertificate	BB	25. Was case referred to medical examiner?	Hagnital:	npatient 2	ED/O	itpatient :		Other	(Check onl		Residence 6	0455	
of Vital ing Physician: After this certi tuneral director	٢	1 ✓ Yes 2 No 27. Manner of Death	28a. Date			ime of Inju		ury at Wor			how injury occu		: Scene
ion trendin leath. tor: A	ation	1 Natural 5 Pend 2 Accident Inves		-24-1	0 fd	11:1	5am ¹□	Yes 2	No 1	ınknow	n		
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death cert hin 24 hours after death. Ithe Funeral Director: After this certificate has been signed by the attendin a	Certification:	3 Suicide 6 X Could	not be 28e. Place	e of Injury - resi		rm, street,	factory, office	building, e					ral Route Number, City OII Crest L Co., Md
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		nysician: To the bes niner:On the basis of and manner si	of examinat									
	Ž	29b. Signature and title of certifie						se number			29d. Date sig		nth, Day, Year)
	ł	30. Name and address of person			. ,	n -			D 6465				
St.	ate	Laron Locke MD. As 31. Date filed (Month, Day, Year)	ssistant Medica 32. Re	strar's Sig		Penn S	treet, Balti	rnore, M	ID 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:15 p August 14, 2010 Calvin Martin Brincefield, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death P.G. Hvattsville 2705 Lackawanna Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Days Hours Min (Month, Day, an. 25, 67 220-40-3529 1943 Director Maryland Jan. Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland P.G. Hyattsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 2705 Lackawanna Street 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 ☑ Yes 2 ☐ No If Yes, Give 1 Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 1966-71 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Air Force Elementary/Seconday (0-12) College (1-4 or 5+) Supervising Contract Specialist Systems Command Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Alda Louise Waigand Calvin Martin Brincefield, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Lackawanna Street, Hyattsville, MD 20783 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Elaine C. Brincefield/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Fort Lincoln Cemetery 1 X Burial 2 Cremation 3 Removal from State August 2010 18 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Metastatic Carcinoma 9 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami sician and burial-transit The law requires that the death certificate be expended that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Year Pregnant at time of death Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertensian, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? certificate 1 Yes 2 No 1 ☐ Yes 2 🛣 No Hospital or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one, examiner? Certificate: To 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Dyedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. пpleted (Check To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D17135 August 16, 2010 reunne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5450 Knoll North, Columbia, MD 21045 Lawrence R. Swink, MD 31. Date filed (Month, Day, Year)

State Registrar 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistraWFND#7perFH,8/17/10,BW,McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day John Paul Benjamin 3:00 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges <u>6333 Naval</u> Lanham (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs. (Month, Day, Yes 1 🕅 M 2 🗌 F Months Days Hours Min. 97 Yrs. Director 51-20-3926 Carolina Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Bant: If item 27 is na reled of other than "natural", or items 23a or 28a-f sho luny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified MD Prince Georges Lanham 1X Yes 2 🗌 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 USA 6333 Naval Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖵 No Specify. Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Private Industry Road Employee Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Benjamin Sylvia Heatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley Benjamin/Son 6333 Naval Ave. Lanham, MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) gton Nat. : 8/13/2010 Suitland, MD
22. Name and Address of Facility Latney's Funeral Home, Inc. Washington Nat. 21. Signature of Funeral Service Licensee 3831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or attending physician and for use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year s been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🐼 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of autopsy performed? death? Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nuyse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MP wo D46591 8/10/10

State

Registrar

Ndubuisi

AUG

7940 Johnson Ave. Glenarden, MD

20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Achufusi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010

			For State Registrar	State of Ma	aryland /	-	irtment of F tificate of L		d Mental Hy		010	27329
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To the Hospital or Attending Physician: The law requires that the de.th certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached or use as the bunal-transit	Me		(Check 2 Medical E only one) 3 Certifying	Nurse Practione	r: To the b	amination a est of my k	and/or investig anowledge, de	ath occurred at the	e time, dat	occurred at the and place,	and due to the	e cause(s	s) and manner a	s state	
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2			Robert F. Lark					vd. Suit	e 20	0, Ge:	rmantov	vn,M	aryland	l Mi	20874
St Regis	tate trar	3	1. Date filed (Month, Day, Year)	16 2010		s Signatur	- 25	parke							

State of Maryland / Department of Health and Mental Hygiene 27331 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22, 2010 **Physician** Elmira Bell 19:50 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Min 1 □ M 2 X F Hours Director 269-12-5114 Maryland May 18, 1919 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral One Kaylor Circle 21532 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: þ Specify Specify 3 X Widowed 4 □ Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other than any linjury or other traumatic event, the once. 12 Beautician Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Kallmyer Grace Neat ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Smith - Great Nephew 16302 Duck Hill Drive, Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State August 24 **Cumberland Crematory** 2010 Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +Sidhu MD filed (Month, Day, Year) 9356 shoot alsh Road, Cumberland, Mary and State AUG 2 5 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Belzora 2010 8:05AM Gertrude Bernard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4315 Maryland Hwy Oakland Garrett 5. Social Security Number 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F Months Hours Director 296-24-8574 Ohio 105 Usual Residence of Decedent 28a-f show 10a. State traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD Garrett Oakland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4315 Maryland Hwy 21550 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baker Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be fill.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Harry Shepard unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bernard/ Son 929 Springfield Ct., Windsor CA 95492 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Gaffett transfer (1917) 4 Donation 5 Other (Specify) 8/24/10 Gardéns Oakland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 1 al 203 S. Second St., Oakland, Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ inunca disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 - Ectopic pregnancy Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown as been signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed Yes 2 _ 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 100 Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pendina Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) 8121,10 ~1533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson MD 311 N Fourth St., Oakland, Year) . Registrar's Signature State AUG 2 4 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 07 12:30A^M 2010 Aug. /Medical Robert Clayton Ball 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Eden, Md. Worcester 8208 Meadowbridge Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Morth, Day, Year) | 12-09-1930 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F 220349366 Yrs Director Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 □Yes 2 □ No Director Md. Worcester Eden 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or 8208 Measowbridge Road 21822 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5± yrs. Elementary/Secondary (0-12) Assistant Director Social Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Be Charles Gladstone Ball Mattie Regina Dykes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Harrington Ball 8208 Meadowbridge Road, Eden Md 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery Important: I any Injury o 08-10-2010 4 Donation 5 ☐ Other (Specify) Eden, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home, P.A. 11673 Somerset Ave., Princess Anne. Md. 23a. Polic. Enter the disease, or complications that Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, occ, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imperiate Cause (Final diese se or condition re-ulting in death) isease Physician Parkinson /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entor Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 The Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57952 8/10/10 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Babulal Das M.D. #106 Milford ST,# 504B, Salisbury, MD 21804

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2010 5:45 A M MARGARET L. BURROUGHS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BRADFORD OAKS NURSING HOME PRINCE GOERGES CLINTON Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) MAY 3, 1922 1 🗆 M 2 🗓 F Months Days Hours Min. Director 218-16-3313 88 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No PRINCE GEORGES CLINTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7520 SURRATTS RD. 20735 IISA 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ρ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8TH HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F JOHN WASHINGTON BESSIE SLYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 short of Health a item 27 is BRENDA B. FISHER-DAUGHTER CLAYTON, NC. KINTYRE DR. 27520 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMETERY 8-18-2010 WASHINGTON, DC 21. Signature of Funeral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND any SUITLAND RD. SUITLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and-tran Due to (or as a consequence of): resulting in death) Last sician a Physician/Medical Box 68760 the b nding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death Dav Year signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has oade performe certificate I 1 ☐ Yes 2 X No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending after death.

Director: Aff in by the fur 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 8/16/2010 D19431

State Registrar 30. Name and address of pe

Ryan,

M.D.

Frank M.

31. Date filed (Month, Day

AUG 1 8 2010

11701 Livingston Rd. #103

Ft. Washington, MD. 20744

n who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AUGUST 13 2010 ar 12:27 AM KHALID AHMED BRADLEY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Center Prince Georges Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex **Funeral** Jan. Day 6 ar) 1975 1 ፟ M 2 ☐ F Warsh.. Director 577-15-2369 show 10a. State 10b. County 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Prince Georges Yes 2 No Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1732 Albert Drive 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Aid PG County Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patricia Tuckson William L. Bradley ^{19a.} Informant's Name/Relationship (*Type, Print*)
Patricia Brantley/Mother 19b. Mailing Address (Street and Number or Rural Route Number City or Jown, State, Zio Code)
1732 Albert Dr. Mitchellville, MD 20721 20a. Met od of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Washington National 8/21/10 Suitland, MD 4 Donation 5 Other (Specify) Name and Address of Facility Priogen Funeral Service 9013 Annapolis Rd Lanham, MD 20706 21. Signature of Funeral Service Licenses awan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ck Physician/ disease or condition Medical resulting in death) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed BUELLO A attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year n signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 🗙 No Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2**∑** No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work' 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) D0034350 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CR2

State Registrar Caterina P. Minniti, MD

Date filed (Month, Day, Year)

AUG 1 8 2010

Server 3. Registrar's Signature

AUG 1 8 2010

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month BETTIS LOUELLA B. 2:12 PM 010 AUG Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death MONTGOMERY 4b. City, Town, or Location of Death **Examiner** ROCKVILLE NATIONAL LUTHERAN HOME 8. Date of Birth Month Day Year APR 1914 9. Birthplace (State or Foreign Country) VASH • rDC Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours 1 □ M 2 □ F 577-07-5919 96 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ROCKVILLE 1 X Yes 2 ☐ No MONTGOMERY MD. 10f. Zip Code 10g. Citizen of What Country? 20850 Completed by Funeral USA 9701 VEIRS DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11 Marital Status Armed Forces Black White etc 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2X No Specify: If Yes Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ᅙ ABRAHAM BAILY LOUELLA BOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, RICHARD BETTIS- SON 322 KINGSTON CIRCLE, SYKESVILLE, MD. 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 8/16/2010 SUITLAND, MD. CEDAR HILL CEM. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servina Licens 22, Name and Address of Facility 2222-WISCONSIN HYSONG CO., INC WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause neach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 1 Yes 2 No Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, æ examiner? Hospital Other 1 🗌 Yes 2 🗔 No ျှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death.

J Director: After tled in by the funera Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Ves 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

State Registrar

31. Date filed *(Month, Day, Year)* **AUG 1 8** 2010 32. Registra s Signature

KARESH-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.

(Check

only one) 29b. Signatiu

and title of certifier

CHARLES

9701-

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20850

ROCKVILLE, MD.

License number

VEIRS DRIVE,

2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	_	For State	Plea	ase Type or State o		and / De	oartmer	t of F	lealth a			/gien	e	ole.	0.7	007
Physicia Medic		Registrar 1. Decedent's Name Beverly				Ce	ertificat	9 OT L	Jeath		2. Date of Do Month August	Reg. Neath	ay Y	/ear	3. Time 6:05	of Death
Examin	er	•	Adventi	n, give street and num st Nursing & 6. Sex	Rehab.		Si	lver	Spring	3	0.0-1(8)	4	Montgo	mery		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	13919 Eds	ied 2 ☐ Mai	12. Was Dece Armed Fo	rces? 2 x No	U.S. 13	. Was Deced If Yes, spec	ify Cuba	ispanic Orio n, Mexican	, Puerto	ecify Yes or No Rican, etc.)			Americ White, o	etc.	
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To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 250 9 ☐ Unknown	months?		Birth 2 🗌 I nant at time	Fetal death 3	☐ Ectopic ☐ Other (sp	oregnanc pecify)	Ç y				23d. Date Monti		ery Day	Year
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5		30. Name and addre	ess of person	who completed caus	se of death (I	tem 23a) (Type		091	205	3 M	DCRN)	August	16,	2010	
Stat	e	Babette Po	ennay, (CRNP 2101	Fairlan	d Road,	Silver	Sprin	g, MD	20904	<u> </u>					
Registra		AUG	17 20	10 Jenes	n B	anature fram									· <u>-</u>	

DHMH 17 Rev 7/2009

			For State Registrar	State of Ma	rylan	d / Depa <i>Cei</i>	artment of rtificate of	Health <i>Death</i>	and M	lental Hy	giene Reg. No	2010)	27338
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	Examir Funeral Director	ner	4a. Facility Name (If not institution, give 5311 Acacia Avenu 5. Social Security Number 6. Social Security Number 11.	e	(In yrs. I	last birthday) Yrs.	4b. City, Town, Be If Under 1 Year Months Days	thes	da er 24 Hrs.	8. Date of Birl (Month, Da 06/13/	th y, Year)	9. B	tgon	e (State or Foreign
200	e Maryland	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ry	10c. City	y, Town or Loo hesda	cation			00/13/			10d.	Inside City Limits 1X Yes 2 □ No
-,	th with th 23a or 29 ust be no		10e. Street and Number 5311 Acacia: Avenue	e			10f. Zip Code	0814			10g. Ci	tizen of What C		?
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Exercitivat coast be recitified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:			Was Decedent of fYes, specify Cub	an, Mexic	an, Puerto	ecify Yes or No Rican, etc.)		14. Race - An Black, Wh Specify:		
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exercitive rust be in titled at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mo	ost of workin	ng	16b. K	ind of Busines Ente Nigh		inment/ Lub
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, Mar	os 1 and 2 should of Health and Mer item 27 Is marke r other traumatic		19a. Informant's Name/Relationship (7 Michel Cadeaux, 1	• · · · · ·		5311	g Address (Stree Acacia, A		, Bet	hesda,	Mar	yland	208	314
timore	permit. Pages 1 Department of I- Important: If ite any Injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. P	Mount Ceme		- 1	08/15	5/2010	Ade	elphi.	Marv	
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			30. Name and address of person who c G. Coleman, 1355 P	iccard Dri	ve,	Rockvi	ille, Man	ylan	d 20	850				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of L	Death	F	Reg. No. Z U	10	21339
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	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		1 ☐ Burial 2 🗷 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crei Cun	matory or other place nberland Crema	e) atory	August 20, 2010			nd, Maryland
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			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between
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			30. Name and address of person who co	ompleted cause of death		Print)			1 1	_	
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per phys. G907 9/1/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 P Aug 14, 2010 Helen Mae Cogswell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Temple Hills Prince George's 6718 Robinia Road If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XXF Months Davs Hours Min Oct 18, 1921 New York Director 578 30 7120 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No Rockville Maryland 1 4 1 Montgomery ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20851 be filed within 72 hours after death with 1110 Agnes Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany no tother traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 7th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fisher Anthony Bertha Wines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Neal (Daughter) 6718 Robinia Road, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Hillcrest Memory Gardens | Aug 21, 2010 Jeffersonton, Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Serv Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Arthymia disease or condition resulting in death) Cardiac <u>Minutes</u> Medical Due to (or as a consequence of): Examiner Years Tachycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Years Pulmonary Fibrosis attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown n signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Spec Hospital: 2 **X** No (Daughters) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) hane 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 3 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number D21392 August 17, 2010 ofteath (Item 23a) (Type, Print) 1201 Seven Locks Road, #111, Rockville, MD 20784 30. Name and address of person who completed caus D. Kellogg, M.D. Patricia 31. Date filed (Month, 32. Registrar's Signature State Darks Registrar

DHMH 17 Rev 7/2009

2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August 2010 2:50 p Josephine Sanford Donaldson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 4000 Elby Street Silver Spring 8. Date of Birth
(Month, Day, Year)
June 13, 1926 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 XX Hours Director 223-24-7276 84 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 Elby Street 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: Specify: White id Mental Hygiene. marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ഉ Millard Filmore Sanford Edna Lee Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3094 Scottsborough Way, Riva, MD 21140 Carolyn Rosengarten/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State Date Augio¹⁹ 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home Inc. Francis J Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Coronary Artery Disease Medical Due to (or as a consequence of): Examiner Diabetes Mellitus, Type II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Thoracic Aneurysm as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 🗷 No 9 Unknown 9 Unknown cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58800 August 16, 2010

Registrar
DHMH 17 Rev 7/2009

State

2101 Medical Park Drive, #300E, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Angela M. Marshall,

72

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:20 AM M 2010 July 10, Beulah Tull Dize /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manokin Manor Nursing Home Princess Anne Somerset If Under 1 Year If Under 24 Hrs. Months Days Hours Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Yrs 95 Virginia Director 220-32-9492 05-08-1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Director MDSomerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21853 11974 Edgehill Terrace Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 2 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Homemaker Own Home none marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental Historia If Item 27 Is marked out Mamie Pusey John Eli Tull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: if Item 27 Is any injury or other trau once. 768 Cedar Hall Road, Pocomoke City, MD 21851 Judy Howard/cousin Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery 07/15/2010 Princess Anne, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 M00295 23a. Fart1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death di ease or condition resulting in death) **Physician** 43CVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): physician Physician/Medical as the attending plant of the last as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

requires that the death certificate be executed Box 68760, P.0. Division or Vital Records, After t

Baltimore, Maryland 21215-0036

Certification:

Medical

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

e Hospital or Attending 24 hours after death. To the Hospitar within 24 hours after death.

To the Funeral Director: Aft

State Registrar 29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D47094

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415, 5. DIVISIUN Sher facisquey

(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 8, 10:45 p Iola Bessie Eby M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care at Asbury Village Gaithersurg Montgomery Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours June 17, 1905 220-07-3679 105 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 10d. Inside City Limits 1 Yes 2 No MD Montgomery 1 Montgomery 1 Gaithersburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 301 Russell Avenue 20877 Usa 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify White Completed 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than ", any injury or other traumatic event, the Mendonce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Electrical Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Leppo Martha Magness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Elder/Social Worker 401 Hungerford Drive, Rockville, MD 20850 Baltimore, Date 19 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Aug. Wesley UMC Cemetery 2010 4 Donation 5 Other (Specify) Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or impury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte Dav Year Pregnant at time of death 5 Other (specify) 2 😿 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 😧 No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merlyn Vemury, MD 9801 Georgia Avenue, #227, Silver Spring, MD 20902 31. Date filed (Month, Day, 2. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

that the death certificate be executed attending physician a for use as the burial-Box 68760 signed by the a P.O. Records, To the Hospital or Attending Physician; The law requires page Division of Vital 24 hours after death.

Funeral Director: After thi eted filled in by the funeral of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Eaton, Ear1 Henry August 4 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Sunrise of Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 20 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ፟ M 2 □ F Days Hours Min. Months New York Yrs. Director **1**920 074-18-1278 90 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 5 10e. Street and Numbe 10g. Citizen of What Country? iral", or items 23a or Examiner must be r 990 Waterford Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.1952-55 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or in the Medical Examin þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medica1 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl H. Eaton Myrtle Thorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Leaswing Court Charles Eaton / Son Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory Creme Place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Vincent 2010 de Paul Cobleskill, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope performed: Nos 2 No 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael W. Costello, M.D., 1564 Opossumtown Pike, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 16 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July STANLEY **EVANS** LEONARD 2020 M 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death SALISBURG ROGIOWAL HICOMICO Peninsula If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Days Hours 213-42-0953 11171371943 Mary land Director 66 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Ewell 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20787 Caleb Jones Road 21824 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 1 Yes 2 No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leonard B. Evans Norma A. Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Evans (Wife) 20787 Caleb Jones Road - Ewell, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Ewell Church Cemetery 07/17/2010 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Ewell, MD 22. Name and Address of Facility Bradshaw & Sons 306 W. Main St. Funeral Home - Crisfield, Robert H. Bradshaw 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Squamous Call Carcinone disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 No Other: ᅌ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.O. Records, of Vital completed filled in by the funeral director, Division To the Hospital o within 24 hours at To the Funeral D

Baltimore, Marvland 21215-0036

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 030690 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) MA Corroll 5%. 25 32 Registrar's Signatur State

1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rosalee James Eldredge 14:44 Buelah Aug 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park, Maryland Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 □ Days Hours Min. Ruby, Virginia 78 **Director** 229 40 8178 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Temple Hills 1 Yes 2 No Maryland | Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 4014 27th Ave 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc. o. þ 1 Never Married 2XXMarried Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Jesse James **Heflin** Omalee *. Page 1 and 2 shou..
** of Health and Me
** of Sin m'
** 27 is m' 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Eldredge (husband) 27th Ave, Temple Hills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 XBurial 2 Cremation 3 Removal from State Stafford, Virginia injury (Rock Hill Baptist Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee $\gamma\gamma$ Ferry Road, Clinton, MD 20735 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ YSFUNTION SYNDROME disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examin sician and burial-transit PNEUMONIA BACTEREMIA Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Pregnant at time of death ed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VAOLONGED RESPIRATORY FAILURE Records, Completed 1 Yes 2 No 3 Probably 4 Onknown SCLERUDERMA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page death? 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 2 FNo Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 Residence 6 Other (Specify) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funeral 28a. Date of injury Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur who completed cause of death (Item 23a) (Type, Print) SUCULIST HOSPITAL, TALLOMA PARK NASK WETON State Registrar

DHMH 17 Rev 7/2009

			1 - For State Registrer		Maryland / De	partme ertifica	nt of Heate of De	alth and I eath		Reg. No.	010	27347
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					Month	Day		9:45 AM
	/Media	cal	Elsie H. Evans 4a. Facility Name (If not institution, given	- street and sumbo	ar)	4b Cib	v Town or Lo	ocation of Death	August		2010 County of Deat	1 0 .
1	Examir	ner	Sunrise Assistar		")				•			
					Age (In yrs. last birthd		olumbia eriyear	l I Under 24 Hrs.	8. Date of Bir	th	oward 9. Birt	hplece (State or Foreign untry)
	Funeral Director			1□M 2XF	95 Yrs	Month:	Days	Hours Min.	July 2			rginia
			Usual Residence of Decedent						roury z	4, 1	71.J. V.1	гушта
	yland		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	War Land	ţċ	MD Howard		Columbia	3						1 ☐ Yes 2 🔀 No
	7 28 th	ire	10e. Street and Number				ip Code			10g. Citi	zen ol What Co	untry?
	738 o	D E	6500 Freetown Ro	ad		2	1044			USA		
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Mudical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Deceder Armed Force		3. Was Dec	edent of Hisp	anic Origin? (S Mexican, Puert	pecify Yes or No)-	14. Race - Ame Black, Whit	
9	or its	F	1 Never Married 2 Married	1 Yes 27		•		Specify:	o i noan, oto.,			
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21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr				sual Occupation	on ing most of wor	kina	16b. Ki	nd of Business/	Industry
2	thin it	n di	Elementary/Secondary (0-12)	College (1-4d	lif	e. DO NOT	use retired)					
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Maryland	2 should be filed v and Mental Hygie te marked other t aumatic event, th	2	George W. Kidwel	1				Mary C.	Kidwel	1		
a L	and and		19a. Informant's Name/Relationship						ral Route Numb			
Σ	alth alth		Robert Draper -	Nephew	166	Latt	ice Ga	te St.,	The Wo	odlar	nds, TX	77382
e e	of He		20a. Method of Disposition	75	20b. Place of Di	sposition (A	ame of other place)	1	Date	20c. Lo	cation - City or	Town, State
Ĕ	Page nt: if ry o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Everly	Crema	torv	8/2	7/2010	Ale	exandri	a. VA
saltimore,	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked any injury or other traumatic e ance.		21. Signature of Funeral Service Lice	nsee			and Address		.,			~ / / / /
m	Departiment in poor in		Van C	1 me	1453	Ever	ly-Whe	atley 1	500 W.	Brado	dock Rd	, Alexandri
	Physician / Medical street pe executed whisician and pural-transit the priral-transit the priral-transit the priral-transit than the priral-transit than the priral-transit than the priral transit th	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence of): as a consequence of): as a consequence of):)e vuin	,			
U. BOX 68/6U,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death	3 ☐Ectopic 5 ☐ Other (23d. Date of de Month	ivery Day Year
ds, P.O.	uires that t signed by Id be detai	þ	Part II. Other significant conditions	contributing to deat	n but not resulting in th	e underlying	cause given	in Part I.			1	o the cause of death?
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<u> </u>	sician: The certificete he rector, page	Be	25. Was case referred to medical				2	6. Place of Dea	ath (Check only	-		
2	Physician: r this certific ral director,	10	examiner? 1 Tes 2 No	Hospital: 1 Inpa	atient 2 ER/Outpa	tient 3	DOA Other:	4 Nursing H	lome 5 ☐ Res	idence	6 Other (Spe	city) Assil Live
			27. Manner of Death	28a. Date of I (Month,	njury 28b. Tim Day Year) Inju		28c. Injury a Work?	t	28d. Describe	how injus	ry occurred	
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Division	Hoepital or Attending Phys 24 hours after death. Funeral Director: After this tely filled in by the funeral dir	Certification:	3 Suicide 6 Could not 4 Homicide determined	4 286. Place of	Injury - At home, larm etc. (Specify)	street, fact	ory, office		281. Location (City or To			ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C			est of my knowledge, d s of examination and/o stated.							
	To the To	Me	29b. Signature and title of certifier				9c. License n				te signed (Mon	
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1	10		30. Name and address of person who			pe, Print)	0 1	1	Mary!	0		•
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Е	Sta	ate	31. Date liled (Month, Day, Year)	32. Regi	strare Signature	1						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 15 pm Day Year Month Physician ATHERTNE 2010 4905 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner APRA NURSING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/15/1917 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1□ M 2€ F 067-01-2290 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10h. County 10d, Inside City Limits 1 ☐ Yes 2 TNo MD Washington Boonsboro Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be n 21713 8507 Mapleville Rd. USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Completed by 3 XWidowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) bookkeeper farm store 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Daisy Thomas Amos R. Keller Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Crone Lane, Middletown, MD 21769 19a. Informant's Name/Relationship (Type. Print)
Nancy Bonde (Niece) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State Reformed Cemetery 8/16/2010 Middletown, MD 4 □ Donation 5 ☐ Othe Specify) ture Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ofications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or cor shock or heart failure. List only Approximate Interval Between Onset and Death The dog Immediate Cause (Final disease or condition resulting in death) **Physician** BRUNCHZPNEUMONIA /Medical Due to (or as a consequence of): Examiner SENIZE DEMENTIN Sequentially list conditions, if any learning Lambda cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed burial-transit Due to (or as a consequence of) or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the g a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTEN SION 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed NON. INSULIN DEPENDANT DIARRETEL 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 certificate has autopsy performed? Yes 2 No 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director; A
bletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 13, 2010 D. 30469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY: + 308, COLUABIA, MD-21045 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 12 ay 201 Year LOUIS FOREMAN HENRY 10:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Date of Disc. (Month, Day, Year) R 1940 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min. Days Hours 1 🕅 M 2 □ F Director Feb.8 212-38-7700 70 Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Maryland Frederick Frederick 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 199 Stonegate Drive 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 'natural", or i 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed **Black** traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) Truck Drive State Roads is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည John Robert Foreman Nellie V. Bowie permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Foreman/ Daughter 199 Stonegate Drive, Frederick, Maryland 21702 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer U. M. Cemetery 8/21/10 <u> Iiamsville Marvland</u> 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown any Homes P. A. Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ardiomy opath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an STroke has autopsy performed? Yes 2 No page 2 Fibrillah'on certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl pleted filled in by the funera 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 060417 8-12-2010

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

homas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sha

31. Date filed (Month, Day Year)

			1- State of Maryland / Dep Registrar Ce	artment of Health and rtificate of Death	Mental Hygie	010 21000
			Decedent's Name (First, Middle, Last)	71170410 07 204111	2. Date of Death	3. Time of Death
	Physici		MICHAEL BARTON FINCH		AUGUST 12.	2010 09:30A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
			10201 GREEN HOLLY TERRACE	SILVER SPRING		MONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 499–34–8467 74 Yrs.	If Under 1 Year If Under 24 He Months Days Hours Min	n (Month, Day, Yea	9. Birthplace (State or Foreign Country) Missouri
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Aaryli f sho	ō		r Spring		1 □Yes 2 No
	289-	rect	10e. Street and Number	10f. Zip Code	10a. (Citizen of What Country?
	3e or		10201 Green Holly Terrace	20902		United States
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
9	or Ite	/Fu	1 ☐ Never Married 25€Married 1 ☐ Yes 2 5€No	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑No Specify:	eno rican, etc.)	Black, White, etc.
8	urel',	d by	3 Widowed 4 Divorced Year or Dates:	/*		Specify: White
21215-0036	n 72 "net	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16b.	Kind of Business/Industry
12	withi	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	diction Counselo:	r	State Government
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, Maid	en Sumame)
lar	uld be Aenta rked tic ev	To B	William Kenneth Finch	Agn	es MacDona	ld
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, I'te Medical Examiner must be notified at	ľ		ng Address (Street and Number or F		
	and ealth m 27 her tr					Spring, Md. 20902
altimore,	ges 1 it of H if iter or oth		I District 2 Micremation 3 Differentiation State	matory or other place)	Date 20c.	Location - City or Town, State
ij	it. Pa rtmen rtent: njury				13/2010 A	lexandria, Virginia
Ba	permit. Pages : Department of the Importent: If ite any injury or of once.		116 Lune m-00470	2. Name and Address of Facility Muriel H. Barber	r Funeral Ho	ome
			23a. Pagh. Enter the disease, or complications that caused the death. Do not en			Lle, Md. 20882 Approximate
E	Physician		shock, or heart failure. List only one cause on each line. Imme late Cause (Final		·	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence of):	c coronary artery	/ disease	
E	Examiner		Sequentially list conditions, b.			
	p ##	iner	frany, leading to immediate auto. Enter thickness the cause (Disease or injury Cause (Disease or			
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	al E	540 10 (3) 40 4 00 100 410 10 5 17.			
687		edical	d			
Вох	that the death certifined by the attending problems as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
œ.	death	lcia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
o.	at the by th stache	hys	9 Unknown 9LJ Unknown			
s,	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	by	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
oro	requi	eted	Hyperlipidemia		1 Tes	2 No 3 Probably 4 Monknown
3ec	has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a			25.44		1 Yes 2	
=	sicie: certii irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	eath (Check only one)	- Clau (2) (1)
Division of Vital Records, P.O.	Attending Physicien: or death. ector: After this certifici by the funeral director,	-	27. Manner of Death 28a. Date of Injury 28b. Time o	f 28c. Injury at	Home 5 sidence 28d. Describe how in	
0	vttending death. ctor: Aft y the fun	atlo	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Σ	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
	urs aff rel Di					
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat one of the death o	n occurred at the time, date and plac vestigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			· Clube Jayans	D 39793	A	ugust 12, 2010
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Christopher J. Mays, M.D. 18111 Pr	Print) Pince Philip Driv	e, Olney, M	d. 20832
	Sta		31. Date filed (Month, Day, Year) 16 2010 32. Registrar's Signature AUG 16.	Sould .		
	Registr	ar	nou a u cui u promoto po			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth Leaetta Fairgrieve Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-Regional Medical Center Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F Days Min. March Day Year 1935 75 Maryland Director 220-32-2503 Usual Residence of Decedent show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 100 Honeyscukle Lane USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Evel Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Textiles Seamstress Be Page 1 and 2 should be filed v ment of Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucinda Wilt Arthur Bowser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 24 W. Main St., Lonaconing, MD 21539 Bonnie R. Miller/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bittinger Cemetery August 23, 2010 Bittinger, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or compile attends a valued shock, or heart failure. List only one suse on each line ns the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 4 CIPAINSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Year Day completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No perform Be B 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? ၉ 1 7 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending
Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 22,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 4 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year 2010 1:10A M Edward Fraiser August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7703 Beechnut Road Capitol Heights Prince Georges Social Security Number Birthplace (State or Foreign Country)
 SC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Ye Feb. 16, Min 1 XM 2 - F Director 099-28-5365 Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD PG Capitol Heights 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7703 Beechnut Road 20743 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married <u>გ</u> Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 - Widowed 4 - Divorced Specify: Completed Year or Dates Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Military Sergeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed int of Health and Mental H t: If item 27 is marked ot Frazier Bertha Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7703 Beechnut Road
Capitol Heights, MD

20b. Place of Disposition (Name of cemetery, crematory or other place)

Disposition (Name of cemetery, crematory or other place) Ruby Fraiser/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 8/23/10 Cheltenham, MD Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 Natural 5 Pending work' To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Secretifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway 31. Date filed (Month, Day, Yea 32. Registra is Signat State AUG 1 8 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ferguson Grimes Nancy 2010^{ar} 1:15 PM August 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bowie Prince George's 12106 Flint Lane If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F Months Days Hours Min Month, Pay Yar 10/1942 Director 1220-48-4030 68 Washington D.C. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Prince George's Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funera 12106 Flint Lane 20715 U.S.A. items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc 1 Never Married 2 Married ò Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Specify: 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked
any injury or other transcorrect. ည Charles F. Leer Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12106 Flint Lane, Bowie, Maryland Richard T. Grimes, Jr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/18/2010 Davidsonville, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Day Year Pregnant at time of death ate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed prior to completion of death? After this certificate Yes 2 No 1 Yes 25. Was case ferred to medical examina? within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioney To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number

State Registrar ulis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#'s 10e. 19b. PerFHPCC8-24-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 15 Day 2010 Year 9:28 Pm Arthur Gabriel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** XX M 2 □ F Months Days Hours Min. 84 0492841926 439-30-0447 Louisiana Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Temple Hills 1 Yes 2 XX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3306 Rickey Avenue Funeral 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Specify: Specify: 3 Divorced Completed Black Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Pharmaceutical Pharmaceutical Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Warehouse vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ပ္ Gabriel Belle Cavatte Lawrence 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine M. Gabriel - Wife Rickey Ave., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) cemetery, crematory or other place, 8/21/2010 Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Sign / re o F / rai Service Lice is 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. onot enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Ph sician/ CANCE OLDN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day signed by the a d be detached f Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🗆 Yes Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Dath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2828 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31

MO

Benjers

31. Date filed (Month, Day, Year)

AUG 18

PiscA+AWAy Rd #600

Clinton

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27355 Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) Month Physician 08-09-2010 16:38 Phillip Eugene Green, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Funeral Hours Days Months 1 MM 2□F 56 08-27-1953 D.C. Director 578-74-1608 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Meryland 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Director Prince Georges Temple Hills 10g. Citizen of What Country? 10e. Street end Number 10f, Zip Code 3202 Curtis Dr. 20748 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Stetus 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0020 Specify: ģ 3 ☐ Widowed 4 Divorced **Black** Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Technician Banking 75 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Cleo Mildred Blaine John Green 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tra pncs. 26 Chinaberry Ln., Indianhead, Md 20640 Keisha Green / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 08-13-10 Chesapeake Crematory 4 Donati 5 ☐ Other (Specify) 21. Signalure of Funeral Sovior Ligens 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Fatal Cardiac Arry
Due to (or as a consequence of):
Septic Shock /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine ettending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the s should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be

or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, efter death

s certificate has t director, page 2 s After this certifications funeral director, I Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 1 Avaturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined To the Hospital or Atterwithin 24 hours efter der To the Funeral Directo completely filled in by the 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Menth, Dey, Yeer) 29b. Signature and title of certifier 29c. License number

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 8416 Central Avenue, Landover, MD 20785 mo Cumberbatch

31. Date filed (Month, Day, Year) State Registrar

AUG 1 8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1515 PM 2010 Martina Shaffer Henderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Hospital Rockville 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral (Month, Day, Year) 1 M 2 5 F Months Days Hours 64 Yrs Washington Jan 9 **Director** 215-46-1393 1946 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Rockville 10f Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1235 Potomac Valley Road 20850 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Charles H. Shaffer Jr. Marie Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Potomace Valley Rd., Rockville, MD 20850 Marie Shaffer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8/17/2010 Baltimore Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Simplte Tribute any MØ141 1040 Rockville Pike, Rockville, MD 20852 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failule. List only one cause on each line. Approximate Interval Between Immediate Cause (Float Onset and Death Physician/ severe 50 one month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner dvanced Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🞾 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 PNo After this certificate 1 Yes Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: မ 1 Penpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural Accident 5 Pending within 24 hours after death.

To the Funeral Director: Afgempleted filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Gertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c

Registrar

DHMH 17 Rev 7/2009

State

10110

molecular Dr Suite 206

Rockville MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2. Registrar's Signature

Davar

05

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27357 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANKLIN LEE HOLMES, JR. 13, August 2010 11:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 407 Myrtle Street Crisfield Somerset Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. October 19' 1957 MaryTand 220-68-7618 Director 52 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 271s marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exartine to the traumatic event, the Modical Exartine to other traumatic and once. 10b. County 10c. City, Town or Location Director 1 XYes 2 ☐ No Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 90 Somers Cove Apartments 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1~4or 5+) Elementary/Secondary (0-12) 10 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Lee Holmes Beatrice June Ward ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Heron Way - Crisfield, Maryland 21817 Deborah Ann Laird (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Crematory of Delmarya Aug. 14, 2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRADSHAW & SORS FORERAL HORE Bracshaw-306 W. Main St. - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (o Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been sig , page 2 should b 3 Probably 1 ☐ Yes 2 ☐ No 4 T Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 🗆 No 1 □Yes 3 25. Was case referred to medical Be 26. Place of Death (Check only one) home of examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) friend Certification: To Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of ce/ 29c, License number 29d. Date signed (Month, Day, Year) 3262 August 13, 2010 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 305 31. Date filed (Month, Day, Year) strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month KATHY LYNN HINMAN 2010 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c, County of Death Examiner 0 Salisbo VICOMICO ۶۲ 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08/19/1956 1 M 2 TRE Months Days Hours Min. Maryland 214-70-7189 53 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Maryland Wicomico 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 21804 333 North Park Drive U.S.A. tems hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 X Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 0 other Be other traumatic event, be filed aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment: Important: If item 27 is marked any injury or call. Dolores Marshall Richard F. Hinman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores M. Hinman (Mother) 1514 Riverside Dr.-Apt. B321 - Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 08/14/2010 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Robert H. Bradshaw, 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco_use contribute to the cause of death? <u>۾</u> 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examplation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Erectioner To the Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

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			For State	State of Ma	rylan	•			and M		001	0	27250
			Registrar			Cei	tificate of	Death			Reg. NG. U	0	27359
	Physici	an	1. Decedent's Name (First, Middle, Last Mary Ellen Hu	ghes						2. Date of Dea	Day	Year 010	3. Time of Death 2:20 a M
1	/Medic		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o	of Death	August	4c. County		
	LAGIIII	CI	Mallard Bay Car	re Center			Cam	bridge	9		Do	orche	ester
	Funeral		5. Social Security Number 6. Se	x 7. Age		last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birti (Month, Day	, Year) , 1924	9. Birth	place (State or Foreign
22	Director		218-16-8125 1L		86	Yrs.				July 1	, 1924	Mar	yland
	yland ow at		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
)	e Mar a-f sh tifled	ctor	MD Dorches	ster			Ca	ambrio	ige				1 ☑ Yes 2 ☐ No
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10e. Street and Number 520 Glenburn Ave	eniie			10f. Zip Code	2161	13		10g. Citizen of V USA	Nhat Cou	ntry?
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ă Z	id 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (T) Kenneth R. Thomas		.r.	1	g Address <i>(Street</i> cademy S						р Соде) 21613
ē,	s 1 ar if Heal item 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla			Date	20c. Location		
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Baltimore, Maryland 21215-0036	ermit. epartr nporta ny Inji		21. Signature of Funeral Service Licens	see	•	I	. Name and Addre						
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8760	cate be executed physician and the burial-transit	dical		d									
9	ertifica ing ph e as th	Med	IF FEMALE:										
Вох	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Feta	Ideath 3□	Ectopic pregnanc Other (specify)	у				ate of deliv onth	very Day Year
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ď.	w requires that the de been signed by the s should be detached i		Part II. Other significant conditions co	ontributing to death bu	t not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco use con	tribute to	the cause of death?
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Vita	s certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ 6	Hospital: 1 ☐ Inpatier	nt 2 🗆	ER/Outpatier	t 3 DOA Oth			n <i>(Check only o</i>	<i>ne)</i> dence 6 ⊟Oti	hor (Snac	(6.4)
0	ig Phy ter this neral c	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	y	28b. Time o					now injury occur		ny)
Sior	tendin eath. or: Af the fur	atio	1				M 1 □	Yes 2□					
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At ho . <i>(Specif</i>)	ome, farm, str y)	eet, factory, office		1	28f. Location (5 City or Tox	Street and Numi vn, State)	per or Rui	ral Route Number,
	spital		29a. Certifier 12 Certifying Phy	vsician: To the best o	f my kno	wiedge, deat	n occurred at the ti	me, date ar	nd place,	and due to the	cause(s) and m	anner as	stated.
	the Ho in 24 h the Fu	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examina	tion and/or in	vestigation, in my	opinion, dea	ath occurr	red at the time,	date and place,	and due	to the cause(s)
	To t To t	Σ	29b. Signature and little of certifier	1/D	1		29c. Licens	se number			29d. Date signe	d (Month)	, Day, Year)
•	6		00 Name (and 11 100)	for \$ 10	2 f	00a) (T	H4	461	5		8/17	/201	0
	ر.		30. Name and address of person yolo o		•		y Drive	('A	who	de	Mary	land	
e e	Sta	to	31. Date filed (Month, Day, Year)	32 Registra	r's Signa	iture	7		VAR V	uge	1.1212	1,0	1

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elizabeth Ann Harding 11, 6:58 P M 2010 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4666 Maiden Forest Road Dorchester Reids Grove 8. Date of Birth (Month, Day, Year) March 29,1917 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F 216-40-4453 93 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Expresser must be notified at Director 1 ☐ Yes 2X No Maryland Dorchester Reids Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 4666 Maiden Forest Road 21659 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ih. M. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Hoffman Katherine Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Foxwell/Daughter 5144 David Green Road, Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 8/14/2010 East New Market, MD 21. Signatur, of Fu eral Service Li Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath Immediate Cause (Final barline **Physician** disease or condition resulting in death) /Medical Examiner alley Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 s been signe should be c 1 Yes 2 No 3 Probably 4 Unknown Sallle Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy To the Hospital or Attending Physician: The performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{\$\alpha\$Residence} \) 6 \(\text{\$\infty} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. Investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Matthew brocker MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 2736 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	cate of	Death			R	eg. No.			
Physicia		Decedent's Name (First, Midd	. ,			-			Date of Dea Month	th Day	Year		3. Time of Death
Medical Exami	ner	LaCole Vero							August 12	2, 2010			0925 hrs
		4a. Facility Name (if not institution Prince George's Hosp				b. City, Town, o	or Location of	of Death			County of ince Ge		s
Funeral	-	5. Social Security Number		e (In yrs. last bi	rthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8	B. Date of Bir				nplace (State or
Director		219-37-9209	1 M 2 F	17	Yrs.	Months Da		Adin	02-14			Foreign	
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any		10a. State 10b. County		10c. City, Tow	n or Locati	on						- 1	10d. Inside City Limits
Aaryland 28a-f show 1 at once.	៦	MD Prince	e George's	Capi	to1	Height	s						1 Yes 2 No
Maryland 28a-f sho d at once	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	n of Wha	t Count	ry?
h the 3a or		5 Cindy Lane	, Apartmen	t 303		20743				USA			
th wit tems 2	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decedent Armed Forces			Decedent of H				- 1	4. Race - White,		an Indian, Black,
er dea			1 Yes 2	No	10	Yes 21X N						D 1	
5-0036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	ð	15. Decedent's Education (Spe	or Dates:	npleted) 16a		's Usual Occup		kind of work	done		pecify: nd of Busi	B1a	
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or			st of working lif							
036 ithin and r than	ם	10th			Stud	ent				PG	Co.	Pι	ublic Sch
5-0 iled w Hygic I othe		17. Father's Name (First, Middle,	Last)	•			18.Mother	's Name (Fi	rst, Middle, M	vlaiden Si	urname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Ricky Hines							Rand1				
D sh as is	-1	19a. Informant's Name/Relations Keesha Tyler,				Address (Stre							
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic		20a. Method of Disposition	re co. Da	20b. Place	of Disposi	rights	emetery,	Ku., 1	Lando ate	ver 20c. Lo	cation - C	ity or T	0wn, State
DOFE But of E		1 X Burial 2 Cremation		ate crema	tory or oth	er place) Nat1.	i			1			
Baltimore, permit. Pages lar Department of Hee Important: If itei	- 1	4 Donation 5 Other Sp 21, Signature of Funeral Service		III a i iii		ame and Addres	and the second second		201	р г	indo	vei	20746
Balti permit. Departm Imports injury o	ļ	Tisha L. Reis	1 mo161	6					11 PA	Ave	S	. 11 i t	cland, MD
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused		ot enter th	e mode of dying	, such as ca	ardiac or res	spiratory arre	est, shock	, or heart	u I	Approximate Interval
/Medical Examiner	ı	Immediate Cause (Final disease	a. Gunshot Wound	of the Hea	d							- 1	Between Onset and Death
Lxammer		or condition resulting in death)	Due to (or as a conse	equence of):									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	equence of):			_					-	
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ed nsit	Exa	events resulting in death) Last	Due to (or as a conse	equence of):									
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760, ficate be g physicia the burit	/Medical	IF FEMALE:	23c. If yes, outcom	ne of pregnancy	_	- 100				23d [Date of de	elivery	
587 ertifica ling p	an/	23b. Was decedent pregnant in the past 12 months?	e 1 Live birth			al death 3	Ectopic	pregnancy			onth	Da	y Year
Box 68 he death certiff to the attending hed for use as	Physician		nown g Unknown	time of death	5 Oth	er (Specify)				4			Į,
the de	吾	Part II. Other significant conditi		but not resultin	a in the ur	derlying cause	given in Par	rt I.	23e. Did to	bacco use	e contribu	ute to th	e cause of death?
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Vital Rec ysician: The his certificate director, page	ပ္ပ	25. Was case referred to medical				26 Place	e of Death (Check only	1 Yes 2	2 No	1	/ Yes	2 No
Vita hysicia this cer) Be	examiner?	Hospital: 1 / Inpatie	nt 2 ER/O	utpatient		Other =	Nursing Ho		Residenc	e 6	Other:	
Division of Vital Records, lal or Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	⊢ h	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of In	ury 28c. Inju	ry at Work		l. Describe h		occurred		
ion tendi leath. tor: /	ertification:	Natural 5 Pend 2 Accident Inves	ing Aug 9, 2010	000	0 hrs	1	Yes 2	No Sui	oject shot				
or Att or Att after d Direct	ţį	3 Suicide 6 Could	not be 28e. Place of Inj		arm, street	, factory, office	building, etc	28f.	Location (S	treet and	Number	or Rura	I Route Number, City
Divi	() F	Homicide	mined (Specify) Liqu						or Town, St 0 Brightsea				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ical	(Check only 1 Certifying Pr	ysician: To the best of my niner:On the basis of exar										
To r with To t	Medical	29b. Signature and title of certifie	and manner stated.		nivoungum	29c. Licens		arrod at tric	time, date c				h, Day, Year)
	-	11/1		RX		O.C.					st 13, 2	•	., Jay, rear)
2	-	30. Mame and address of person	who completed cause of de	eath (Item 23a)									
2 4		Russell Alexander MD			111	Penn Street	Baltimo	re, MD 2	1201				
	ate	31. Date filed (Month, Day, Year) AUG 1 8 2010	32. Registrar	Signature	Kel								
Regist	rar	HOP I & SOL	centra p	1900							CMF		
										- 43	1 × 12.7 fee		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day THOMAS AUGUST 2010 10:05a M GARFIELD HERNDON. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHANTI HOME LAUREL PRINCE GOERGES Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 X M 2 - F Hours Min. MAY 6, Director 578-28-9543 83 Yrs 6, Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 1 ☐ Yes 2X No MD PRINCE GOERGES LAUREL 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13551 BELLECHASSE BLVD #212 20707 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 1 930 1952 If Yes, Give 1 9552 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0 3 1 Never Married 2 X Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced BLACK the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event than 11-1 Elementary/Seconday (0-12) College (1-4 or 5+) 2YRS POSTAL WORKER US POSTAL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ THOMAS GARFIELD HERNDON, SR. LUCIA MARIE GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLLYE HERNDON - WIFE BELLECHASSE BLVD #212 LAUREL, MD. 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN MEMORIAL CEM: 8-20-2010 SUITLAND, MD Signature of paneral Service Licensee MARSHALL HOME OF MARYLAND 4308 SUITLAND RD. SUITLNAD, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition Cardiac Dysrhythmia Medical resulting in death) Due to (or as a consequence of) **Examiner** End Stage Alzheimer's Disease Sequentially list conditions, If any, leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Hypothyroidism that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Chronic Kidney Disease Box 68760 as the b IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month 5 Other (specify) Day Year 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy certificate Yes 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 4 □ Nursing Home 5 □ Residence 6 🖾 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DQA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be

To the Hosp within 24 hor To the Fune completed fi

Hospital

State Registrar

Medical

29a. Certifier

(Check

only one)

3

29b. Signature and title of certifie

Samuel Semegan, 31. Date filed (Month, Day, Year AUG 1 8 2010

12201 Plum Orchard Dr. M.D. 32. Registra 's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

nul

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Silver Spring, MD 20904

29d. Date signed (Month, Day, Year)

2010

1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

48152

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Alphonso Henson 2010 August 12:10 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4000 Mitchellville Road, Suite 208 Prince George's Bowie Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 02/04/1939 1 № M 2 🗆 Months Hours Director 217-34-1743 Bowie, Md Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits be notified Prince George's Md. Bowie 1 🙀 Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 13118 11th Street 20715 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give filed within 72 hours after 2x No 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: 3 Widowed 4 Divorced Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Porter 2 vears Race Track Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alphonso Henson Doris Prout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annastasia Henson/Wife 13118 11th St., Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other placel Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 08/21/10 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland . Signature of Funeral Service Licenses Name and Address of Facility ington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Respiratory Failure Due to rras a consequence of: Medical Examiner Terminal Colon Cancer with Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 L 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Patient was DNR - No CPR certificate has I 1 Yes 2 No completed filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence & Other (Specify) Office Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending death. ☐ Accident ☐ Sulcide 1 Yes 2 No after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certi-29c. License number D 34525 29d. Date signed (Month, Day, August 16, 2010

State Registrar

MAILLIAM

DHMH 17 Rev 7/2009

4000 Mitchellville Road, Suite 208, Bowie, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sankineni Rao, M.D.

31. Date filed (Month, Day, Yea AUG 1 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Charles Dennis Ignasias 0525 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico BISPAN Haningula Realismal Madical Center If Under 1 Year 8. Pate of Birth **Funeral** 9. Birthplace (State or Foreign Months Days 09/26/1939 ^{Co}Michigan Director 370-40-5483 70 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland| Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31921 Quail Ridge Drive 21804 U.S. filed within 72 hours after death val Hygiene. Jother than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☑ No
If Yes, Give
Year or Dates. 1960–1962 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Vice President Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic ever 2 Page 1 and 2 should be ment of Health and Ments Charles Henry Ignasias Elsie M. Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Molly Lionberger 128 Carolyn Avenue, Salisbury, Md. 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 07/24/2010 Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 Ave, Princess Anne, Md. 21853 7 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between mediate Cause (Final eum ma Physician/ disease or condition resulting in death) Medical Due to lor as a consequence of): Examiner Sequentially list conditions, if any list of the cause. Enter Underlying Physician/Medical Examiner ms signed by the attending physician and defacted for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 No 3 Probably 4 Unknown 1 Yes peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital or within 24 hours a To the Funeral D 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD.

egistrar's Signatur

069634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav 2:20 Ann M. Johnson A M /Medical 10 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery

9. Birthplace (
Country) 5. Social Security Number If Under (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√ F Months Days Hours Min 297-44-9322 80 Yrs. Feb. 10 1930 Rhode Island Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner count by northlyd at Director MD Gaithersburg 1 X Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 301 Russell Ave. Rm 312 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event. In Exercise 2008. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ Roy A. Henrikson Helen Abby Tolhurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey C. Johnson/ Son 31586 Mayfair Lane, Beverly Hills, MI 48025 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 8/19/2010 | Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20853 23a. Part 1. Er er the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, r h art failur Immediate Cause (Final disease or intion resulting in death) **Physician** 'ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unicase or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending PhysIclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 🗹 No 1 🗆 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: Al 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and tite of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 10,2010

State

Registrar

30. Name and address of pers

31. Date filed (Month, Day, Year)

even

Russell

6 zithers burg

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

olinsky

2010

911

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 | 0

Certificate of Death

		•	State Registrar			-	Ce	rtificate of l	Death	,	Reg. N		1 U	21366
	Physicia	n/	1. Decedent's Name	(First, Middle, L	ast)					2. Date of De	eath	_	Voor	3. Time of Death
	Medic		LAWRENC			ACKSON				AUGUST	- 8	^{lay} 20)ŶÎŮ	2241 p M
Œ	Examin	er	4a. Facility Name (if r	_					r Location of Dea	th		c. County o		
		_	SOUTHERN 5. Social Security Nu		ND HOSPI'		not hirthdow	CLINTO		B O Data of Di		PRINCE		
	Funeral Director		578-78-3 Usual Residence of I	3593	1 ⊠ M 2 □ F	. Age (In yrs. Ia	Yrs.	Months Days	Hours Min		ay, Year)	55	9. Birthp	place (State or Foreign try) DC
	at at	or	T	10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
	faryla Ba-f : tified	ect	MD	PRINCE	GEORGES	DIS	STRICT	HEIGHTS						1 ☐ Yes 2 🌠 No
	the N	۵	10e. Street and Num					10f. Zip Code			10g. C	Citizen of W	hat Coun	itry?
	with s 23a nust t	Funeral Director	5901 KEN	TUCKY A	VE			20747	7			USA		
	death item ier m	Fur	11. Marital Status		12. Was Decede		3. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	-			an Indian,
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 X Never Marrie 3 Widowed 4		1 X Yes 2 If Yes, Give Year or Date	1973 -	.	1 ☐ Yes 2 🖾 No		,		Specify:	B $1a$	
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ary	nould Ind M s mar		19a. Informant's Nar	ne/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or R	ural Route Numb	er, City o	or Town, Sta	ate, Zip C	Code)
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ore	of He of He roth		20a. Method of Dispo		Removal from S			osition (Name of matory or other place	ce)	Date	20c. I	Location - 0	City or To	wn, State
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Baltimore,	permit. Depart Import any inj		21. Signature of Pune	eral Service Lice	A. Wot	dD)	м 4	2 Name and Address ARSHALL S 308 Suit]	ss of Facility S FUNERAI	L HOME O	F MA	ARYLAN	ND 2074	¥6
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€	Medical		resulting in death)		- d-	as a consequ		yenmia					_	
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n o	d ing l h. After funer	cate	1 Natural 2 Accident	5 Pending	(Month,	Day, Year)	injury	work	yat ⟨? Yes 2 □ No	28d. Describe	now Inju	iry occurred	1	
Sio	I or Attend after death Director: /	Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 200 Place of	Injury - At hor	me, farm, str	reet, factory, office	103 2 🗆 140	28f. Location (Street au	nd Number	or Rural	Route Number,
Ö	al or safte		4 🗆 Homicide		building	, etc. (Specify)				City or To				,
_	To the Hospital or A within 24 hours after to To the Funeral Dire completed filled in bire.	Medical	29a. Certifier 1 [(Check 2 [only one) 3 [Medical Exai	ysician: To the bes miner: On the basis urse Practioner: To	of examination	and/or inves	stigation, in my opini	on, death occurred	at the time, date	and plac	e, and due t	to the cau	use(s) and manner stated
	To the somp	2	29b. Signature and ti		1 Se Flactionel. 10	the best of my	Kilowiedge,	29c. Licens		lace, and due to ti		ate signed (
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Á	2 1. 1		30. Name and addres	ss of person who	completed cause	of death (Item	23a) (Type, I	Print)	-/			-		
1	3+1		Wendell P			503 Su		s Rd. C	linton,	MD. 2073	35			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brandlya Kachko August 23, 2010 ar 9:00A. Medical Facility Name (if not institution, give street and numb Examiner Silver Spring 4c. County of Death Montgomery 1913 Treetop Lane, Apt.#14 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😿 F Months 214-37-3667 Mar. 1921 89 Director Ukraine Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Maryland Silver Spring 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1913 Treetop Lane, Apt.#14 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 X No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3X Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maria (unk) Moses Kachko 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zio Code, 10737 Deborah Drive Potomac, Mary Land 20854' Raisa Ionin -granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Judean Memorial Gdns.:8/26/2010 Olney, Maryland 21. Signature of Funeral Service Licensee Bonald Aves Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Congestive Heart Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Cardiomypathy Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nunsequence of Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) vate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1
Yes 2
No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Valve Sclerosis; Coronary Artery Disease Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 24 No 2 🔀 No 1 🗌 Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 👿 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of After t Certificate: 1 X Natural injury 5 Pending 2 Accident Investigation within 24 hours after deat To the Funeral Director: 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46364

State Registrar 31. Date filed (Month, Day, Year)

AUG 31

Felix B. Sokolsky, M.D. 11125 Rockville Pike, #203 Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

August 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 State Registra AMEND#31, see#32, 8/17/10, EWW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 3:54 Manohar Purshottam Kharkar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 1009 Downs Drive Silver Spring 5. Social Security Number Birthplace (State or Foreign Country)
 Tundia If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 X M 2 D F 1 1 / 0 7 / 1 9 2 5 123-70-2397 84 India Director Usual Residence of Decedent or 28a-f shov 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Lehigh 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 1730 Central Park Avenue U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced Asian Indian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h n and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Airline Aeronautical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sumitra Gupte Purshottam Kharkar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1009 Downs Drive. Silver Spring, Maryland 20904 Salil Kharkar - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 08/17/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Anheller cityes |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD - Lipids 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗆 Yes 2 🎗 No Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier MD427406 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schuha Norman ton 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

1/0/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Katherine Kellev August 7:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🖾 F Months Hours Min. Washington, DC **Director** 214-80-4950 51 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6842 Farmbrook Court 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deli Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John F. Meese, Sr. Lillian Lucille Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary N. Kelly, Sr. / Husband Farmbrook Court Frederick, Maryland 21703 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State August Stauffer Crematory 4 Donation 5 Other (Specify) 16, 2010 Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the di.) ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in iter. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ WALLIBE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ Inpatient 2 - ER/Outpatient 3 - DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Box 68760 P.O. Records, Hospital or Attending Physician: of Vital n 24 hours after death.

e Funeral Director: Afte Division completed

State Registrar DHMH 17 Rev 7/2009 29a. Certifier

(Check

only one 29b. Signature and title

30, Name and address of

701564

Kupi

person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Baltimore, Maryland 21215-0036 Fermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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	ď	For State Registrar		State of M	aryland	•	artment of	Health and I <i>Death</i>	, ,	JIENE Jeg. No. 2	וחי	Ω	271	370
DI -1-1-	,	1. Decedent's Name	e (First, Middle, La	st)					2. Date of Deat	th	. U . ,		3. Time of	Death
Physicia Medic		Carolyn							Month Aug. 16	5, ^{Day}	10	ear	7:3	0 a ^M
Examin		Holy Cro	ss Hospi	e street and number) tal			Silve	er Spring		4c. Co	Mon		nery	
Funeral Director		5. Social Security No. 259-64-1	646	Sex 7. Ag ☐ M 2 🔀 F	e (In yrs. Ia 68	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan• 14	4 ^{Year)} 19	42 g	Birthpl Countr Geo	ace (State or y) gia	Foreign
a-f show fied at	Director	Usual Residence of 10a. State	10b. County			, Town or Lo						10	d. Inside Cit	
23a or 28 st be noti	eral Dir	MD 10e. Street and Nun 12921 T	l <u>Montg</u> No Farm	.	51.	iver :	Spring 10f. Zip Code	904	1	10g. Citize	n of Wha	t Count	ry?	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status	ied 25 Married	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - A Black, V ecify:	Vhite, et	tc.	
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Departr Importa any inju		21. Signature of Fur	neral Service Licen	see Ool	4	2 <u>F</u> 5	Rame and Addr Tancis J 00 Unive	ess of Facility COILins rsity Blv	Funeral	Home	In Sp	Ç. rinç	, MD	20901
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	~ I	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 g ☐ Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 🗌 Fetal	death 3	Ectopic pregnan Other (specify)	су		230	d. Date o Month		-	ear
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or cor		29b. Signature and t	Suff	th				55069			gust		ay, Year) , 2010)
		30. Name and addre	Lemma, N	completed cause of de ID 1500	Fore	23a) (Type, F st G1	en Road,	Silver S	oring, M	D 209	01			
Stat Registra	е	31. Date filed (Month		32. Registra										
		700		M		Y #								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 12, 2010 Year 11:15 A M Physician/ Anne Lucas D. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Bradford Oaks Nursing Facility Clinton 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2**X**XF If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Hours Months 1¹²7¹287 1912 Washington, DC 578-07-1421 97 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b County 10a. State must be notified at Director 1 Yes XX No Clinton Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 23a 20735 7520 Surratts Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Mercede Piro ဂ္ DiMeglio 1 Giuseppe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3918 Burgenland Lane Cincinnati, Ohio 45255 Son Joseph Lucas Α. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 08/16/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Juneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. P. ft 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nock, or heart failure. List only one cause on each line. Imme e Cause (Final disease or condition eukemi Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 【XNo
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 🔲 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: XX Nursing Home 5 Residence 6 Cher (Specify) Hospital 2 X X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No 1XXNatural 5 \square Pending injury 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of 08/12/2010 MICH MD D0052999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI RAHI MIAIN, IN D CLINTON MD 20735 Drive- G-06 10403 HOSPITAL 31. Date filed (Month, Day, Year) State AUG 1 8 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shirley June Marshall 10:03ам August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2232 Kingshouse Road Silver Spring Montgomery 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Ye Months Days Hours Min Director 328-22-8383 81 llinois Usual Residence of Decedent 28a-f show ural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2232 Kingshouse Road 20905 U.S.A. be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working ntal Hygiene. ed other than " event, the Mes Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Library Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Levi Carter Pauline Brown Overbu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Johns - Sister 2232 Kingshouse Road, Silver Spring, Maryland 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 08/16/2010 | Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. nnellaucharner 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertensive Arteriosclerotic Cardiovascular Diseas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death l by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autonsy performed?

Yes 2 X No after death.

Director: After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 1 🗌 Yes 2 🗶 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after.

To the Funeral Direct determined 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20904 Leibowit 2 Victae E-11120 31. Date filed (Month, Day, Year)

State Registrar Registrar's Signature

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Physicia	an/	1. Decedent's Name (First,	Middle,Last)						2. Date of D	Reg. No eath	0.		B. Time of Death
Medical Exami		Steven G. Ma	neer							Month August	Day 9, 201	Year 0		1338 hrs
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		4001 Yarmonth L						wie			- 1	Prince Ge	•	
Funeral Director		5. Social Security Number	6. Sex		7. Age (In	yrs. last birth		Inder 1 Year onths Days	If Under 24H Hours M	lrs. 8. Date of lin.	Birth(MN	M/DD/YYYY)	9. Birth	olace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	4001 Yarmout	n Lan	12. Was Dec	edent Ever	intlS		715	anic Origin? (Specify Yes or I	USA		Amoriaa	n Indian, Black,
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, P.O	d b		_					_		1 Y	es 2 🔽	∕ No 3	Probabl	y 4 Unknown
ords, w requir	Completed									24a. Was				sy findings available
Reco The law icate has	틹										ormed?	dea	th?	pletion of cause of
tal Recian: The certificate	ပ္ပုံ	25. Was case referred to me	dical					26.Place of	Death (Check	1 Yes	2 N	lo 1 🗸	Yes	2 No
of Vital Records, ig Physician: The law requir the this certificate has been si meral director, page 2 should be	ď	examiner? 1 ✓ Yes 2 No	Hos	spital: 1 Ir	npatient 2	ER/Outp	atient 3			ng Home 5	Reside	ence 6 🗸	Other: Sc	cene
ding Phy After tl	اۃ	27. Manner of Death		28a. Date of	of Injury	28b. Tír	ne of Injury	28c. Injury a	at Work?	28d. Describe	how inju	ury occurred		
Division tal or Attendi rs after death. al Director: A	읉		Pending Investigation	FOUND: Aug 9, 2		FOUN 1333 h		1 Yes	2 🗸 No	Subject she	ot self			
ViS or At or At or at or at in by			Could not be	28e Place			, street, facto	ry, office build	ding, etc.	28f. Location or Town,		and Number of	or Rural	Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide	determined	(Specify)	At home	e				4001 Yarmor	nth Lan	e, Bowie, N	ID	
ne Hos n 24 h ne Fur										d due to the cau				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the:	ᄝ		a	n the basis o	i examinatio ated.	on and/or inve				at the time, date				
	2	29b. Signature and title of ce	nitier	10.00			2	9c. License n				Date signed		Day, Year)
		m	ni.	V				O.C.M.I	⊑. ————		Aug	just 10, 20	טרנ	
2		 Name and address of pe Ling Li, MD Ass 		npleted cause dical Exam	•	,	Street, Bal	timore ME	21201					
Sta	to i	-			istrar's Sigr		Jueer, Dal					-		
Registr	ar	31. Date filed (Month, Day, You AUG	6 201	0 /2	ر شدهد		back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 08-11-2010 2:49 PM Earlene Ragland Gray Moore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 G Months Davs Hours Min 0 7-22-1952 577-74-0088 58 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shomust be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. **Funeral Director** 1 1√2 Yes 2 □ No Prince George' Forestville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 8744 Ritchboro Road 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No "natural", or ò 1 Never Married 2 Married laltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify:Black Completed 3 Widowed 4 Divorced th and Mental Hygiene.
It is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Carrier US Postal Service 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Irving Ragland Gloria Mathis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kiviette Gray/daughter 8744 Ritchboro Rd., Forestville, MD 20747 item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Suitland, Maryland 08-19-2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Tisha R. Cedar Hill FH, 4111 PA Ave., Suitland, MO1616 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as care lac or respiratory arrest, shock, or heart failure. List only one cause on each ling Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death 5 Other (specify) the s g 🔲 Unknown g Unknown P.O. signed by the he underlying cause given in Part Part II. Other 23e. Did tobacco use contribute to the cause of death? 1 Yes Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1- Natural the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After t 5 Pending M Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined within 24 hours a
To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practionar To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

AUG 18 2010

August 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

atevenis, MD

3001 Hospital DR

Cheve

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State	partment of Health and N ertificate of Death		
			Registrar 1. Decedent's Name (First, Middle, Last)	crimeate of Beath	2. Date of Death	ZUU 3 Time of Death 5
	Physicia Medic		LUCIA MARIE HERNDON MATTHEWS		AUGUST	12 2010 7:45 A M
w.	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death PRINCE GEORGES
	Formul		1910 OAKWOOD ST. 5. Social Security Number	TEMPLE HILLS y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
H	Funeral Director		579-26-9311 1□M2XF 86 Yrs	Months Days Hours Min.	APR 2, 1	924 Country DC
	nd now	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	larylar 3a-f sl	Funeral Director	MD PRINCE GEORGES TEMPLE	HILLS		1 ☐ Yes 2 🛣 No
	the N a or 28		10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
	ns 23 must	ner	1910 OAKWOOD ST.	20748	neify Voc or No	USA
~	or iter	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. 1 ☐ Never Married 2 🔯 Married 1 ☐ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - American Indian, Black, White, etc.
93	irs afte iral", I Exar		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:		Specify: BLACK
15-(72 hou "natu ledica	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of work , DO NOT use retired)	sing 16	6b. Kind of Business Industry
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4 or 5+)	OMINISTRATOR		EPT OF LABOR
nd	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural" or items be notified at other traumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	'	ne (First, Middle, Mai	· · · · · · · · · · · · · · · · · · ·
Maryland	uld be I Ment narke natic	잍	THOMAS GARFIELD HERNDON, SR.		RIE GREEN	
Ma	2 sho Ith and 27 is r		19	ailing Address (Street and Number or Rui 10 OAKWOOD ST。 MPLE HTLLS。MD。207		ly or Town, State, Zip Code)
e,			20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)		Oc. Location - City or Town, State
imc	Page 1		4 Donation 5 Other (Specify) LINCOLN	MEMORIAL CEM. 8-19		JITLAND, MD.
Baltimore,	permit. Page Department of Important: If any injury or once,		Ulalarine L' Woods	MARSHALL'S FUNERAL 4308 SUITLAND RD.	SUITLAND,	MD. 20746
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
8	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Due to (or as a consequence of):	Arrest		Onset and Death
Y	Examiner			Obstructive Pulmon	ary Disea	se
		iner	Sequentially list conditions, it any, leading to immediate Due to (or as a consequence of).			
	cuted	xam	Cause (Disease or iinjury that initiated events resulting in death) Last Cause (Disease or iinjury that initiated events resulting in death) Last Cause (Disease or iinjury that initiated events or iinjury that iinjury	Heart Disease		
0	rate be executed physician and the burial-transit	edical Examiner	resulting in death) Last			
68760	ficate g phys as the		- C			
39 ×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death			23d. Date of delivery Month Day Year
Box.	the at	ysic	in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		
P.O.	that the ned by detact	y PF	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part 1.		cco use contribute to the cause of death?
ds,	w requires the special	ted k				2 □ No 3 □ Probably 4 🛣 Unknown
of Vital Records,	law re nas be e 2 sho	Completed			24a. Was an autopsy perform	od2 death?
l Re	n: The ficate or, pag		25. Was case referred to medical	26. Place of Death (Che	1 🗌 Yes 2	
Vita	ysicial s certi directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other:		ce 6 Other (Specify)
of	ng Phy fter thi	te:]	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year) 28b. Time (Month, Day, Year)	ry work?	28d. Describe how	injury occurred
sion	ttendi death. stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Stre	et and Number or Rural Route Number,
Division	alor A safter I Direct d in by		4 Homicide determined building, etc. (Specify)	, 665, 165	City or Town,	
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier (Check check 2 Medical Examiner: On the best of my knowledge, de only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
O			1//Weld Clanuder	MD19730		8-16-2010
n	17		30. Name and address of person who completed cause of death (Item 28a) (Ty		ngton, DC	20010
L	Sta	ate.	31. Date filed (Month, Day, Year) 32. Registrar's Signature		igcoit, DC	20010
	عاد Registı		31. Date filed (Month, Day, Year) AUG 1 8 2010 Aug 1 8 2010 Aug 2 8 2010			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of F tificate of L		d Mental Hy	giene Reg. N	7 11 11 11	27376
	Physicia		Decedent's Name (First, Middal LILLIAN MANS						2. Date of De Month AUGUS		ay 2010 Year	3. Time of Death
de plant	Medi-		4a. Facility Name (if not institutio	n, give street and number)			4b. City, Town, or				c. County of Dea	12:30 p M
	Funeral		6817 PRINCE G 5. Social Security Number		e (In yrs. las	st hirthday)	TAKOMA If Under 1 Year	PARK If Under 24 H	lrs. 8. Date of Bir		ONTGOME	
	Director		579-32-4888	1 □ M 2 ¬ F 81		Yrs.	Months Days	Hours M		y, Year	.928 WASI	thplace (State or Foreign buntry) HINGTON, DC
	and show	Ď	Usual Residence of Decedent 10a. State 10b. County	у	10c. City,	Town or Loc	ation	-				10d. Inside City Limits
	Maryl 28a-f notifie	Funeral Director		OMERY	TAKO	MA PAF	K.					1 X Yes 2 □ No
	vith the 23a or st be r	ralD	10e. Street and Number	IODODO AND			10f. Zip Code				itizen of What Co	,
	leath v items er mu	Fune	6817 PRINCE GE 11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	20912 as Decedent of Hi	spanic Origin?	(Specify Yes or No-		TED STA'	
36	after or all, or ixamin	d by	1 ☐ Never Married 2 ☐ Ma 3x ☐ Widowed 4 ☐ Divorce	If Yes, Give	No		Yes, specify Cuba ☐ Yes 2 🗓 No		erto Rican, etc.)		Black, White	e, etc.
2-0	hours hatura dical E	lete	15. Decede	Year or Dates. ent's Education est grade completed)	Т	16a. Deced	ent's Usual Occupa	ation		16b. F	Kind of Business	LACK
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland Ital Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DC	ind of work done d NOT use retired)	-	vorking			,
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ylar	ould be fi d Menta marked matic ev	욘	JACOB M. KENNE	Y					AN E. LOV		· ·	
Mai	2 should Ith and Me 27 is mar traumati		19a. Informant's Name/Relations QUENTIN CHARLE		/son				Rural Route Numbe	-		,
ore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic.		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of		AVE TAKON		ocation - City or	
ţ	permit. Page Department o Important: If any Injury or once.		1 ☐ Burial 2 😾 Cremation 4 ☐ Ponation 5 ☐ Other (Specify)		SAPEAK	atory or other place E CREMAT	ORY 8/	19/2010		TSVILLE,	
Ba	permi Depar Impor any ir		21. Signate of Funeral Service	Liversee	5				OHN T. RI WASHINGT(AL HOME, LLC
				r complications that caused only one cause on each line	the death.	Do not enter	the mode of dying	, such as cardi	ac or respiratory an	rest,		Approximate Interval Between
	Medical		Imm dia & Cause (Final dise see r condition resulting in death)	a. END ST			DISORDER				_	Onset and Death YRS
	Examiner	7.	Sequentially list conditions,	b. DIABETE	ES							YRS
	nted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate baucs. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a							100	YRS
	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a	conseque	nce of):		_				
1760	icate b g physi	fedical		d. CORONAR	KY ARI	TERY D	ISEASE					YRS
89 ×	ath certifica attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregnance 2 Fetal of		Ectopic pregnancy			ļ	23d. Date of deli	ivery
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Р.С	v requires that is been signed be should be deta	ğ	Part II. Other significant condition			ting in the un	derlying cause give	en in Part I.				the cause of death?
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tal	rsician: The la s certificate ha lirector, page 2		25. Was case referred to medical examiner?				26. Pla	ce of Death (Ch	1 🗆 Yes eck only one)	2 X No	1 ∐ Yes	2X No
<u> </u>	Physic rthis c	욛	1 Yes 2 XNo 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of injury		R/Outpatient 8b. Time of		4 ☐ Nursing	Home 5 X Resid			fy)
ouo	ending sath. rr. After	licate	1 Natural 5 Pendir 2 Accident Investig	ng (Month, Day,	Year)	injury	28c. Injury work? M 1 🗆 Y	at ′es 2 □ No	28d. Describe h	ow injury	y occurred	
Division of Vital Records,	or Atte after de Directo in by th	Certificate:	3 Suicide 6 Could 4 Homicide determ			e, farm, stree	t, factory, office		28f. Location (S City or Town			al Route Number,
ם		Medical	29a. Certifier 1 X Certifying (Check 2 Medical E	Physician: To the best of m	ny knowled	lge, death oc	cured at the time, o	date and place,	and due to the cau	ise(s) an	d manner as stat	ted.
	o the Print 2.		only one) 3 Certifying 29b. Signature and title of dertifler	Nurse Practiona: 10 the b	est of my ki	nowledge, de	ath occurred at the	time, date and p	place, and due to the	cause(s	and manner as	stated.
	F > F 0		· alles	1 Keil	les	MI	D5474				te signed <i>(Month,</i> UST 17,	
	6		30. Name and address of person of ATTEN PETITY MO									
F	State	e .	ALLEN REILLY M 31. Date filed (Month, Day, Year) AUG 182010	Server 32. Registry	iOOSE 's Sign	AVE.	D-I FREDI	ERICK, I	MD 21701			
	Registra	r	AUG 1 8 2010	Clevery B.	ga	ver						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHRISTOPHER COLUMBUS August 2010 OWENS, JR. 2:19 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death McCready Memorial Hospital Crisfield Somerset. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) **Funeral** Months Days 212-40-8438 **Director** 68 September 28, 1941 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amp Injury or other traumatic event, Item Modifical Evantications to the state of the source. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Maryland Somerset Crisfield 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 127 N. Somerset Avenue - Unit 102 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1965— If Yes, Give Year or Dates: 1967 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No White ģ Specify 3 ☐ Widowed 4 🗷 Divorced Specify 1967 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)]] Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christopher Columbus Owens Esther Elliott ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Bradshaw (Sister) 5111 Old Auger Road - Crisfield, Maryland 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva Aug. 14,2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Leth Bradshaw Mary 306 W. Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONEL BUIL /Medical Due to for as a consequence of) Examiner Sequentially list conditions, Dual to (or as a consequence of) Examine and the standing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 2 No 3 Probably 4 Unknown Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 68760, attending p been signed by the should be detached s certificate has b irector, page 2 sl within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

		244. Was an autopsy and autopsy performed? performed? death? 1 \(\subseteq 2 \) \(\subseteq 0 \) \(1 \) \(\subseteq 2 \) \(\subseteq 0 \) \(\subseteq 2 \) \(\subseteq 0 \) \(\subseteq 2 \) \(\subseteq 0 \) \(\subseteq 2 \) \(\subseteq 2 \) \(\subseteq 0 \) \(\subseteq 2 \) \(\subseteq
25. Was case referred to medical examiner?	26. Place	of Death (Check only one)
Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nu	ursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation	1	28d. Describe how injury occurred No
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, date an niner: On the basis of examination and/or investigation, in my opinion, dea	Id place, and due to the cause(s) and manner as stated. Ith occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

39813

29d. Date signed (Month, Day, Year)

August 13, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Atkins, M.D. - 201 Hall Highway - Crisfield, Maryland - 21817

31. Date filed (Month, Day, Year)

29b. Signature and title of pertifier

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:30p M Michael Anthony Papillo August 12,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery 11505 Parkedge Drive If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 050-24-0276 1 🔀 M 2 🗆 F NewYork 1272779929 80 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified Rockville Md Montgomery 1 🗆 Yes 2 🗶 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11505 Parkedge Drive 20852 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ٥, 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White "natural", 3 Nidowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Executive I.B.M. Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Lopresti Joseph Papillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18005 Wheatridge Drive Germantown, Md20874 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Greq Papillo/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buria 2 XCremation 3 Removal from State 8/13/2010 Chesapeake Crem. Beltsville, Md 4 Donation 5 Other (Specify) 21. Signatur Fun al Service Lice PHTETF CORTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a Id be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's disease, carcinoma of bladder 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? 2. K. No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🕇 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0025232 August 13,2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Allotey M.D. 12450 Parklawn Drive Rockville, Md 31. Date filed (Month, Day, 2. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ Pianka 2320 M Helen, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anchorage Nursing + Renabilitation Salisbury MD WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Country) Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County at 10c. City, Town or Location Director r 28a-f sk notified a Maryland Somerset Princess Anne 1 Yes XX No 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 21853 USA 11930Drexwood Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
White þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3XX Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salisbury University Health Service Supervisor 12 t. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosalie Adams Roger Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Riverview Terrace - Lake Wylie, SC 29710 19a. Informant's Name/Relationship (Type, Print) Lisa Moeller (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Paul's Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/22/2010 Wenona, Maryland 4 ☐ Donation 5 ☐ Other (Specify) BRADSHAW & SONS FUNERAL HOME ary Beth Bradshaw-Prui 22. Name and Address of Facility Main Street - Crisfield, Maryland 21817 306 W. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Lung Physician/ Cancer disease or condition Medical resulting in death) Due to (or as Consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit DM Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ▼ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 057952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babulal Das. MD. = 106 Kelford 87 # 504B. Salisburg, MD 2180/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

		For State Registrar	State o	of Marylar		artment of F		Mental Hy	giene 2 0	110	273	380
Physicia Medic		1. Decedent's Name (First, Middle Ina H. Parrish	, Last)					2. Date of De August	eath	l Ö ^{rear}	3. Time of I	Death AM
Examin		4a. Facility Name (if not institution, Crofton Care at	-	nber)		4b. City, Town, or Crofton	Location of Death	h	4c. County Anne	y of Death Arun (de1	
Funeral Director		5. Social Security Number 232-34-3484 Usual Residence of Decedent	6, Sex 1 □ M 2 🗴 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir 04//09/2	th 1/91-8	g. Birthp Count Virgi	place (State or try) nia	r Foreign
aryland ia-f show ified at	ector	10a. State 10b. County	e George's	s loc. Ci	ty, Town or Lo	cation				1	0d. Inside City	•
with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number 12732 Buckinghan	n Drive			10f. Zip Code 20715			10g. Citizen of U.S.A.	What Coun	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	e ² X No	li li	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Bla	ce - Americ ck, White, e	etc.	
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Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Ve	cemetery, crem Mary terans	sition (Name of Jatory of other plac land Cemetery	08/1		20c. Location Chelter	nham,	Maryla	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 D Fet nant at time of	tal death 3 🗌	Ectopic pregnanc Other (specify)	у			ate of delive	*	'ear
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20		30. Name and address of person v Dr. Rakesh Aro 31. Date filed (Month, Day, Year)	ra. M.D.	14300	<u>Gallant</u>		e, Bowie	, MD 207	715			
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		State Registrar		Certificate	of Death	Reg.	No UIU	2/381
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Director	4	Usual Residence of Decedent	12			Dall. 10,	1936 Mai	ylanu
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and 2 Health		20a. Method of Disposition		Disposition (Nan	ore Avenue,		21601 c. Location - City or To	NO State
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Dallillor permit. Page 1 Department of Important; If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Shring				ral Home P	
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og Ph ter th		27. Manner of Death 1 Natural 5 Pending	late of injury 28b. Ti	ime of 28	Bc. Injury at work?	28d. Describe how in		
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To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	4 Hamicida determined 286. P	lace of Injury - At home, farr uilding, etc. (Specify)	m, street, factory	office	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
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vit Solo		29b. Signature and title of certifier		29c.	License number		Date signed (Month, E	
1,		Tall Sand 1		Ima Dist	287776	-	1 - 10	-
10		30. Name and address of person who completed	pause or death (Item 23a) (T	yha Perint)	DA , NO	216	0	
St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	adel				
Regist			abead a B. S.	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tyrone Pettiford 2010 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner TYRONE PETTIFORD SR. 0555 hrs August 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Mill Point Shore at Chaptico Wharf St. Mary's Chaptico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 X M 2 F 03/10/1948 Country) DC 213-46-7099 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Figure 1 MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked and St Mary's Bushwood Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 36851 Sandy Lane 20621 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Black Specify: \$ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs Deputy Sheriff PG County Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter Pettiford Bertha Emerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Pettiford - Wife Sandy Lane Bushwood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State important: Lincoln Memorial Cem 8-16-2010 Suitland, MD 4 Donation 5 Other Specify: Signature of Funeral Service License ²² Name and Address of Facility Marshall's funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - trans sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other4 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: Drowned in river 1 Natural FOUND 5 Pending 1 Yes 2 ✓ No the Aug 9, 2010 0555 hrs 2 🗸 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Chaptico Wharf, Chaptico, MD (Specify) River Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 9, 2010 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year

DOME

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf g907 9-16-10 vt/gs
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 400 A M ALBERTA PARKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months (Month, Day, Year) AUG 26, Davs WASHINGTON, DC 579-42-6511 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at with the Maryland Director 28a-f 1 🛚 Yes 2 🗆 No PRINCE GEORGE'S MD LANDOVER 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 8121 ALLENDALE DRIVE 20785 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ COMPUTER ANALYST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher ည RAYMOND CARTER LUCY CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Department of Health ar Important: If item 27 is any injury or other trau 1001 WHISTLING DUCK DRIVE UPPER MARLBORO, MARYLAND RONALD COLMORE/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND HARMONY CEMETERY 8/21/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the cach. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 X No 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rhoumatoid Arthritis 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Mitral Volve Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 2 No 1 ☐ Yes 2 🙀 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 1 ☐ Yes 2 🗶 No Hospital Other: မြ 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director. After completed filled in by the funer X Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenbelti 204

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>010</u> Physician/ Month Lynne Robinson August 8 2:05 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 11/05/1940 1 M 2 X Washington, DC Director 579-52-9778 69 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 K Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Road 20850 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced "unknown White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Murray M. Robinson Ethel Chessin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Royte Number, City or Town, State, Zip Code) C/O Potomac Valley Nursing Center 1235 Potomac Valley Road, Rockville, Maryla Agent for Potomac Valley NursingCntr Donna Kibbe, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Adas Israel
Congregation Cemetery

08/16/2010 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Sign ture of Luner Servis, Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Ph, sician/ Metastatic Renal Cell Carcinoma Years Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Dav Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? eral Director: After this certificate I filled in by the funeral director, pag 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D38262 August 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2401 Research Blvd, Rockville, Maryland

MD, FACP,

32. Registrar's Signature

Anurita Mendhiratta,

17

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Anna Marie Robe 2. Date of Death 3. Time of Death Robertson Physician/ 4:10 PM August 18 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Moran Manor Nursing Home Westernport 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 216-09-7661 **Funeral** 5 19<u>14</u> Dec. 25 1 M 2 XF Months Days Hours West Virginia Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Allegany Westernport 1XXYes 2 □ No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21562 328 Front United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14, Race - American Indian Black, White, etc. Specify: white Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2/ is marked other than "natural", traumatic event, the Medical Exar 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life, DO NOT use retired) (Specify only highest grade completed) during most of working should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Restaurant and entary/Seconday (0-12) College (1-4 or 5+) unknown Cook and Cleaning School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) <u>,0</u> Winifred Donahue Joseph Mills 1 and 2 should be if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 88, Rawlings, Maryland 21557 Orville J. Knott/son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 08/22/2010 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Westernport, Maryland St. Peters Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home once, 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Wronam disease or condition resulting in death) era Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 5/40 Other: ၀ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work?
1 Yes 2 No 1 Natural 5 Pending death. Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 1 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22-1244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jesus Tan, 4 Broadway, Frostburg, MD 21532 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 2 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Sylvia Gray ŽÖ'10 6:00 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** East New Market 5932 Heritage Road Dorchester 5. Social Security Number 8. Date of Birth Sept. 16,1923 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 218-34-9558 Director 86 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester East New Market 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5932 Heritage Road Completed by Funeral 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) assistant manager department store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Russell Lewis Alma Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn O'Connor daughter 5932 Heritage Road, East New Market, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park | 8/16/10 Cambridge, MD 21. Signatu / If Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 h w Tlomes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Vascular Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Performed?

Yes 2 No 1 ☐ Yes 2 ☐ No the Funeral Director: After this certific npleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

To the

(Check

30. Name and add

Pa

29b. Signature and title of certifie

100 Bramble

ess of person who completed cause of death (Item 23a) (Type, Print)

ohnson

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Shlesinger 12 5:00a M David August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 🗆 F Hours Min Country) ew York **Director** 111-01-1707 New Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director chrm ty Yes 2 ☐ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 East Jefferson Street #422 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. al Hygiene. d other than "natural", or itr event, the Medical Examine If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced Completed WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+Lawyer Legal other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked out any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) Leon Shlesinger Jennie Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 Elizabeth Shlesinger, wife 1801 East Jefferson Street, #422, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 X Removal from State Maimonides Cemetery 08/16/2010 Elmont, New York 4 Donation 5 Other (Specify) Sgnature of Fun and Servic Licensee 22 Name and Address of Funeral DIRECTION, INC. MO1255 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Inter the Wicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown s been signed by I should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 잍 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) cal 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sandeep Sharma,
31. Date filed (Month, Day, Year)

D0064624

743 Summer Walk Drive, Gaithersburg, Maryland

August 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Sylvia Sapperstein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Apt #515 4450 South Park Avenue, Chevy Chase If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** April 06 1 □ M 2 🏿 F Days Months Hours Min. **Director** 216-01-5350 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director Chevy Chase Maryland Montgomery 10f. Zip Code 10e. Street and Numbe ö 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 4450 South Park Avenue, Apt #515 20815 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jacob Sodden Lena Nevanowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Birch Street, Washington, DC 20015 <u>Richard Sapperstein - Son</u> 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State King David Mem. Grdns: 08/15/2010 | Falls Church, Virginia 4 Donation 5 Dother (Specify) of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M01241 |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No should be detached g Unknown The law requires that the P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes Mellitus Completed 24a. Was an cate has page 2 s performed? Yes 2 X No or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of

23d. Date of delivery Month Year Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 🗌 Yes 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D3335 August 13. 2010 5530 Wisconsin Avenue. Chevy Chase, Maryland 20815

12:45 pm

Montgomery

u.s.A.

Own Home

9. Birthplace (State or Foreign

White

Approximate Interval Between Onset and Death

Country) Maryland

10d. Inside City Limits

1 Yes 2 X No

State Registrar

To the Funeral Director: After completed filled in by the funer

24 hours

To the I within 2

Certificate:

Medical

1 X Natural

2 Accident
3 Suicide
4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Lee Jonathan Musher.

29a. Certifier

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

MM

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Harry Marvin Snyder Sr. 182000 7:00 AM tugust Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours Min 214-36-0963 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Clear Spring 10d Inside City Limits filed within 72 hours after death with the Maryland Funeral Director Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 S. Mill Street P.O.BOX 86 21722 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever III 0.5.

Armed Forces?

1 X Yes 2 No 6 - Year or Dates. 1956 - 7 Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th grade Union College (1-4 or 5+) Union Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Marie Mills Charles Jesse Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 86 Clear Spring, MD 21722 Ruth L. Snyder spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Aug Dat 1, 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 万 ☐ Other (Specify) Clear Spring, MD 2010 21. Signature of Fin al Service Lice 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximation of the disease of the death. Do not enter the disease of the disease of the disease of the disease of the disease of Approximate Interval Between Onset and Death eft Immediate Cause (Final certhrovoscula Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner occide Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Heen, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit augestive Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Day Month Veat 1 ☐ Yes ∠ □ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier HOSpitalisT 29c. License number 29d. Date signed (Month, Day, Year) 2010 mult Decello HO06111 E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251

WH-3+1

Registrar

State

31. Date filed (Month, Day, Year)

AUG 20

2010

DHMH 17 Rev 7/2009

Hac

evstoun

Do

Daniels

32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryland		artment of I tificate of I		Mental Hy	giene Reg. No.	10 27390
	Physicia		1. Decedent's Name (First, Middle, Last	id Sprin	raer	•		2. Date of De Month	/ Day /	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s	Rood	J	4b. City, Town, o	Location of Death		4c. County	of Death
	Funeral Director			X 7. Age (In yrs. la	st birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th y, Year) G 1932	Birthplace (State or Foreign Country)
		ة.	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation			471102	10d. Inside City Limits
	e Maryla r 28a-f s notified	Directo	MD Ceci	L	E1.	Kton 10f. Zip Code		- "	40-00	1 🗆 Yes 2 🗡 No
	n with the is 23a or	Funeral Director	216 ElKmore	Road		21				USA
5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba December 2 No.	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
0-61	72 hour an "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wor	rking	16b. Kind of Bu	usiness Industry
ZLZ	ed within Hygiene. other tha	Be Col	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	D	irector	18 Mother's Nar	me (First Middle	Maiden Surname	Line
Maryland	uld be file Mental narked c	10	George D. Spi	ringer, SR.			He	len 1	100 NS	
	and 2 should Health and Me tem 27 is marl		19a. Informant's Name/Relationship (Ty) Gail Springer	wife Wife	1	ng Address (Street E IKMOT E.	and Number or Ru Road	ELK for		21921
altımore,	Page 1 ar nent of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	emetery, cren	sition (Name of natory or other pla Hovy Serv		Place 9/2010		City or Town, State
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service License		51	Name and Addre	ss of Facility		reral Ho Newark	me
	Physician,	r. 23	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.			ng, such as cardiac	or respiratory a		Approximate Interval Between
٠	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ		e peuc	Disco	se		Unknown
	d Sit	Examiner	Cequentially fiet conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	sate be executed physician and the burial-transit	al Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
3/60	ificate be ig physic as the bu	Medical	IF FEMALE:	d				<u>.</u>		
BOX PB	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnan Other (specify)	су		23d. Dat	te of delivery nth Day Year
IS, P.O.	uires that th in signed by uld be detac	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown
or Vital Records,	The law rec cate has bee page 2 sho	Completed						24a. Was auto perfo 1 \square Yes	psy prmed?	Were autopsy findings available orior to completion of cause of death? Yes 2 No
Vitai	nysician; nis certifii I director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐		nt 3 🗆 DOA Oth	lace of Death <i>(Che</i> ner: 4 Nu <u>rsing</u> F		dence 6 🗌 Othe	er (Specify)
on of	nding Pl ath. :: After th e funeral	Certificate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	wor		28d. Describe	now injury occurre	ed
DIVISION	I or Atte s after des Director		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)		eet, factory, office		28f. Location (City or To		er or Rural Route Number,
_	Hospita 24 hours Funeral eted filled	ledical	(Check 2 Medical Examin	a Broatianou To the best of my	and/or inves	tigation, in my opini	on, death occurred	at the time, date	and place, and due	e to the cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifer	e Practioner: 10 the best of my	Milowieage,	29c. Licens	se number	ave, and due to the	29d. Date signed	(Month, Day, Year)
	12		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, F	Print)	T01-1	MAR	1001	7.2010.
	Sta		S. S. Sqchdev 31. Date filed (Month, Day, Year) AUG 17 2010	32. Registrar's Signat	E TU	gh of	Echlar	1110/2	74.	
	Registra	ar	AUG 17 ZUIU	Cenera P. M.	THE PARTY OF	•				

		For State Registrar 1. Decedent's Name (First, Middle, L	actl		Certificate of	Death	2. Date of Dea	Reg. No 2 0 [2739 3. Time of Death
sicia		2	with				Month OS	Day Year 24 201	1-16
dic nin		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town,	or Location of Dea	th	4c. County of De	
			2037 Frostburg		lav) If Under 1 Year		ostburg		Garrett
il r		5. Social Security Number 6. 262-34-0893 Usual Residence of Decedent	Sex 7. Ag 1 ■ M 2 F	e (In yrs. last birtho	Months Days		. (Month, Da	er 26, 1926	irthplace (State or Forei Country) South Carolina
		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limi
ĺ	Director	Maryland	Garrett			Frostbur			1 □Yes 2 N
	Dir	10e. Street and Number	Frostburg Road	4	10f. Zip Code	21532		10g. Citizen of What (Oountry? USA
	Funeral	11. Marital Status	12. Was Decedent I		13. Was Decedent of If Yes, specify Cul		Specify Yes or No-	14. Race - An	nerican Indian,
	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ▼Yes 2 □ N If Yes, Give Year or Dates:	No	1 □Yes 2 No		to Rican, etc.)	Black, Wh	ite, etc. White
l	Completed	15. Decedent's l (Specify only highest g	Education		ecedent's Usual Occu		rkina i	16b. Kind of Busines	
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	ပိ	12 17. Father's Name (First, Middle, Las	o st)		Д			Maiden Surname)	nstruction
	To Be		Ransom Earl S	Smith				Lonis Durham	
	-11	19a. Informant's Name/Relationship		19b. M	,			er, City or Town, State	
	95		ger - Friend	Tool Bi (B)				urg, Maryland,	
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	sposition (Name of crematory or other pla umberland Crem	i i	August 25, 2010	20c. Location - City of Cumber	land, Maryland
۱		21. Signature of Funeral Service Lice	ensee		22. Name and Addr	ess of Facility	Eichh	orn-McKenzie	Funeral Home
ı		23a. Part 1. Enter the disease, or co	Wom			t Main Street		Lonaconing, N	AD 21539 Approximate
	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to financialty cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of,: a consequence of):	art Failure Failure				
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of d Month	lelivery Day Year
	ρ	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did to	311.4	to the cause of death? Probably 4 Unkno
	plete						24a. Was autop perfo 1 □ Yes	psy prior to rmed? death	autopsy findings availa o completion of cause ? es 2 🖾No
	Com					26 Place of Do	ath (Check only o	ne)	
ı	Be Completed	25. Was case referred to medical examiner?	Hospital:		_ Ot	han			
	o Be		28a. Date of Inju	ent 2 ER/Outpa	e of 28c. Inju	her: 4 Nursing		dence 6 Other (Sp	pecify)
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١	o Be	examiner? 1 Yes 2 Ho 27. Manner of Death 1 Matural 5 Pending	28a. Date of Inju (Month, Date)	y, Year) 28b. Tim Inju	e of 28c. Inju	her: 4 □ Nursing lury at lark? □Yes 2 □ No	28d. Describe h	now injury occurred Street and Number or	
	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	28a. Date of Inju (Month, Date)	ry, Year) 28b. Tim Inju ury - At home, farm c. (Specify) of my knowledge, d f examination and/	eath occurred at the or investigation, in my	her: 4 Nursing lary at krk? Yes 2 No time, date and plac opinion, death occ	28f. Location (SCity or Townstee, and due to the curred at the time,	Street and Number or wn, State) cause(s) and manner date and place, and d	Rural Route Number, as stated. ue to the cause(s)
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Larry Wayne Schrader Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner egional Malkall 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Days Min Months Hours Country) 215-54-2624 58 Director 07 - 20 - 1952Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Md. Somerset 1 Yes 2 X No Princess Anne 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21853 United States 13411 Harrison Landing Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 1 🗌 Yes 2 🗹 No Specify: "natural". White 3 UWidowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12)
H. S. Graduate College (1-4 or 5+) Horse Trainer Horse Farm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry L. Schrader Evelyn Loller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13411 Harrison Landing Road, Princess Anne 21853 19a. Informant's Name/Relationship (Type, Print) Derorah Murray Schrader 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 08-12-20L0 4 Donation 5 Other (Specify) Salisbury Md. Salisbury Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home, P.A. M00295 11673 Somerset Ave., Princess Anne, Md. As 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final Chrono Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s or Attending Physician: The law autopsy performe death? _2 XN 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🔲 Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After leted filled in by the funer (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature 2 ē itle of certifie

State Registr<u>a</u>r 30. Name and

Maryland 21215-0036

Baltimore.

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

e of death (Item 23a) (Type, Print)

nD

			1 - State of Maryland Registrar	Certificate of De		Reg. N2010	27394							
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Howard Beckwith Simmons		2. Date of I Month Augus	Day Yea	3. Time of Death 8:45 a M							
N. O. O. O.	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death	4c. County of D	eath							
med.			Mallard Bay Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. las	Cambri			ester							
b	Funeral Director	Completed by Funeral Director	214-42-9578 ¹ ☑ ¹ ☑ ¹ 2□ ^F 67		f Under 24 Hrs. 8. Date of B Hours Min. (Month, Aug.		Birthplace <i>(State or Foreign</i> Country) [aryland							
	Maryland -f show ied at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
	e Mary Ba-f sh stiffed		MD Dorchester		1 X Yes 2 No									
D	death with the ms 23a or 28e r must be noti		10e. Street and Number 10 Railroad Avenue	631	10g. Citizen of What USA	Country?								
L,	death		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.								
36	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examiner must be notified at or other traumatic event, the "Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates;		Specify:	Specify: W								
21215-0036	72 hou natura Ilcal E	eted		on ing most of working	16b. Kind of Business/Industry									
121	within iene. than "	duc	Elementary/Secondary (0-12) College (1-4or 5+)	er	trans	transportation								
	be filed that Hyging of other event, I	BeC	17. Father's Name (First, Middle, Last)	3. Mother's Name (First, Midd	. Middle, Maiden Surname)									
Maryland	should be fand Mental s marked of umatic eve	၉	Lawrence Fletcher Simmons		line Wolff									
	nd 2 sho alth and I 27 is me er traume		19a. Informant's Name/Relationship (Type. Print) Richard L. Simmons son	19b. Mailing Address (Street and 5075 Gina Lane		-								
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placer.	ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City	or Town, State							
Itim	artmen brtant: Injury	. 3	4 ☐ Donation 5 ☐ Other (Specify) East 21. Signature of figure all Service Licensee	. 8/13/10	/10 East New Market, MD									
Ba	Depared Important Important In	Š	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613											
	Physician /Medical Examiner	67	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Special Settlements of the disease of the dise											
			Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive pulmonary disease 20 years Due to (or as a consequence of):											
-		L	bronchiectasis 54											
	uted d insit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): COYONAY A CAYY A SOA											
o,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and raid director, page 2 should be detached for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequent)		7 - 0,5									
68760,		edical	d											
Box (eath certifi attending I for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant in the part 10 program 1 □ Live birth 2 □ Fetal de			d. Date of delivery								
O. B	he deal the att	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown		- Month	Month Day Year								
ď.	ires that the de signed by the a d be detached to		Part II. Other significant conditions contributing to death but not resulting	in Part I. 23e. Di	id tobacco use contribute	contribute to the cause of death?								
ords	v require been sig should b	Completed by	diabetes,	1	Yes 2 □ No 3 □	3 ☐ Probably 4 ☐ Unknown								
of Vital Records,	he law e has b ige 2 sh	mple			24a. W au pe	topsy prior erformed? death	autopsy findings available to completion of cause of 1?							
ital	sician: The l certificate har rector, page	Be Co	25. Was case referred to medical examiner?	24	1 ☐ Yes 6. Place of Death (Check onl	′es 2 □No								
of V	Physic this ce	၉	Hospital: 1 Inpatient 2 EF	7	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred									
	ding After fune	ation	1 Natural 5 □ Pending (Month, Day, Year) Accident investigation	se now injury occurred	/ occurred									
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombullding, etc. (Specify)	28f. Location City or 1	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	spital nours a neral C		29a. Certifier TE Certifying Physician: To the best of my knowle											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.			·								
	5 ≱ 6 ©		29b. Signature and title of certifier	29c. License no 40059		29d. Date signed (M	ontn, Day, Year)							
	5		30 Name and address of person who completed cause of death (Item 2:			1 01110								
	<i></i>	10	Patridia Johnson 100 Brad 31. Date filed (Month, Day, Year) 2. Registrar's Signatur	3a) (Type, Print) Cambr	idg MD									
	Sta Registr		AUG 13 2010 Lender A. Apare											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland Registrar		artment of H tificate of D			ene 201	0	27395						
	Physicia		1. Decedent's Name (First, Middle, Last) Hallet A. Saunders, Sr.	_		2. Date of Death Month August 15, 2010				3. Time of Death 8:56 P M						
ر مد	Medic Examin		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Clin	Location of Death		4c. County of Death Prince George's								
Ā	Funeral Director		5. Social Security Number 6. Sex 125−16−5763 15	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Birthplace (State or Fo								
		or	Usual Residence of Decedent 10a. State 10b. County 10c. City, To			10d. Inside City Limits										
	or 28a-f	Director	Maryland Prince George's Temp		1 Q. Citizen of What Country?											
	th with the ms 23a commust be	To Be Completed by Funeral	3500 Brinkley Road		10f. Zip Code 20748			USA								
9036	urs after deal ural", or iter Il Examiner		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No WWI.	T If	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 ;∑ ¶No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black								
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "nat , the Medica		(Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	lent's Usual Occupa kind of work done d O NOT use retired) Fronics Er	luring most of worki	ng	Sb. Kind of Bus ${ m ederal}$		9						
land	d be filed of filed of filed of firked other tic event,		17. Father's Name (First, Middle, Last) Henry Saunders			18. Mother's Name Florence	(First, Middle, Ma	iden Surname) Turnque	est							
Mary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.					Rd., Tem				ode) .						
more,			1 TRurial 2 Cremation 3 Removal from State cem	etery, crem	sition (Name of natory or other place Veterans	e) !	26/2010 C	oc. Location - C Cheltenl	,	,						
Balti			21. Signature of Funeral Service Licensee		Name and Addres 60 Oxon Hil	is of Facility Geo 11 Road Oxon	orge P. Kal n Hill, Mar		al Hor 20745							
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Vital	ysician: The s certificate director, pag	Be	25. Was case eferred to medical examinar? 1 Yes No Hospital: Inpatient 2 ER.	/Outpatien	Othe	er: 4 \ Nursing Ho		se 6 □ Other	(Specify)							
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_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral dir		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my kn	nd/or investi	igation, in my opinio	n, death occurred at	the time, date and p	place, and due t	o the caus	se(s) and manner stated.						
	Vith con		29b. Signature and title of certifier		29c. License	number /	A (I. Date signed (Month, D.	ay, Year) 6/20/0						
2	6+1		30. Name and address of Jerson who completed cause of death (Item 23	a) (Type, Pr	Arasto	Yazdani	Da W	020	73.	5						
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	2												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Man	ylanc	d / Depa <i>Cei</i>	artmen rtificat	t of H	ealth a	and M	1ental H	ygien Reg. N		2	273	96
	Physicia	an	1. Decedent's Name Tanya To		e, Last)								2. Date of I	D		ear	3. Time of	М
	/Medic Examin		4a. Facility Name (If	·	, give street and n	umber)			4b. City,	Town, or	Location of	of Death	Augus	-	<u>, 2010</u> c. County of D		5:15	р
	xuiiiiii	-	Hebrew H	lome of	Greater	Wash:	ingt	on		Ro	ckvi	11e			Me	ontg	omery	
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🔀 F			st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Day, Year	r)	Countr		or Foreign
	Director	}	213-37-80 Usual Residence of		}	81	Yrs.					02/22/1929			Ukraine			
	yland IOW		10a. State	10b. County		10	0c. City,	Town or Lo	cation							100	d. Inside C	ity Limits
chrm	Man Befsh	tor	Maryland	Montg	omery		Der	wood									1 XYes	2 🗌 No
J.7	or 28	Oire	10e. Street and Nun	nber					10f. Zip	Code				10g. C	itizen of Wha	it Countr	ry?	
	s 23e	rall	7901 Capr	icorn				1			0855	1.0.0				SA	a ladia.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other treumetic event, it a Medical Erani or must be notified at once.	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed		ied 12. Was De Armed F 1 [] Yes If Yes, G Year or	Forces? 2 12No Sive	erin U.S	i	Was Deced fYes, spec 1 ☐ Yes				ecify Yes or to Rican, etc.)	NO-	14. Race - A Black, N Specify:	White, et Whi	tc.	
0	2 hou	ted t		15. Deceden	t's Education			16a. Dece	dent's Usua	I Occupa	ation			16b.	Kind of Busin	ness/Indi	ustry	
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Š	d Mer marke metic	၉	Michael Z					19h Mailir	na Address	/Street a			al Route Nun		or Town Sta	ate Zin (Code)	
Z	Ith an 27 Is		Milla Skl						_				ce, Dei					855
ē,	item other		20a. Method of Disp				20b. Pla	ace of Dispo metery, crei	sition /Nar	ne of	1		Date		Location - Cit			
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2	uted ansit	min	Sequentially list contain, leading to incause. Enter Under Cause (Disease or that initiated events	rtying injury														
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99)	artifica ing ph e as ti	Med	IF FEMALE:		1													
90°	ath ce	lan/	23b. Was decedent in the past 12			birth 2 [Fetal	death 3[Ectopic pr						23d. Date o Month		-	Year
Division of Vital Records, P.O. Box 6	Attending Physicien: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown	1 00	4∐Preg 9☐Unk	gnant at tim nown	ne of dea	ath 5L	Other (sp	ecify)								
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rds	w requires that been signed be should be deta	ed by	Depression								1 Yes 2 No 3 Probably 4 Unknown					Unknown		
CO	aw rec as bee 2 shot	Completed	Pulmon agy embolism							24a. Was an 24b. W			ere autopsy findings available or to completion of cause of					
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on C	After funera	lon	27. Manner of Death 1 Natural	5 Pendir		e of Injury onth, Day Y	'ear)	28b. Time o Injury	M 2	8c. Injury Work	rat ⊲? Yes 2. □	No	28d. Describ	e how inj	ury occurred			
<u>s</u>	Vitlandi death. ctor: A y the fu	ertification;	2 Accident 3 Suicide	investi 6 🗆 Could	not be	ce of Injury	- At hor	ne, farm, str	_		103 2	1	28f. Location	(Street a	and Number o	or Rural	Route Nurr	nber.
ο	2 # 5 =	ertii	4 Homicide	determ		ding, etc. (001, 100101	, 000			City or 1	о̀wп, Sta	te)			
	Hospi 24 hou Funer fely fill	edical	29a. Certifier (Check only one) 29a Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (check only one)									er as sta	ated. the cause(s	5)				
	within 2 To the comple	Me	29b. Signature and	title of certifie	11.				290	. License	number				late signed (A		Day, Year)	
	•		· Y	C4)	CM	~	S			D69	956	8		8	/12/1	0		
_			30. Name and ad re		who completed car	51 m	ont	rose 1	Print)	ک <i>ە</i> دلە	cille	٠, ٣	1D 2		manufacture for the first of th			
4.	Stat Registra		31. Date filed (Mont	17 20	10 Augu	Registrar's	Signatu	pare	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#10e+19operFH, 8/18/10, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 7:17 pm 2010 Lang Kim Tan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Social Security Number . Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral CountryVietnam Days Months Hours Min 11/30/1939 Director 586-14-7866 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Germantown Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Castle Funeral 20876 U.S.A. 58 Drum Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: Asian "natural" 3 Divorced 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 25 should be more thand Mental Hygiene.
27 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be in ment of Health and Menta Thanh Huong Ngoc Ly Tan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 58 Drum Circle Court. Germantown, Maryland 20876 Thanh Pham - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/21/2010 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, e of 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death certificate has been signed by the irrector, page 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospita Other: 욛 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 8 116/10 D021214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste #203, Silver Spring, Md 2090Z

Registrar DHMH 17 Rev 7/2009

State

HESHMAT

M.D.

10301

Georgia

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Marian Pritchett Todd 8:44 a M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Dorchester Cambridge Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours (Month, Day, Year, Maryland 85 214-16-4058 Director Oct. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Toddville 1 🗌 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1913 Wingate Bishops Head Road 21672 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces Black, White, etc Baltimore, Maryland 21215-0036 $^{\prime\prime}$ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 Yes 2 No Specify: white Completed 3 x Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) crab picker seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Warren S. Pritchett Maggie Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a tant: If Item 27 is Lynn Todd 1911 Wingate Bishops Head Rd, Toddville, MD 21672 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 8/18/10 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CORONAry artery disease or condition resulting in death) Medical Due to (or as a const uence of) Examiner OGERS Sequentially list conditions, Examine it any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lo as a consequence of or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 R/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner∕of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 3 29b. Signature and title of certifier 16/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge MD. ohnson

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #4 per FH G907 9/13/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daniel Phillip Physician/ Vinci August 21, 2010 1705 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22300 Seldom Seen Road Allegany Lonaconing 5. Social Security (4) be If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-16-9517 1 🔀 M 2 🗆 F Months Days Hours Min oct. 13 Mary Land 84 1925 **Director** Usual Residence of Decedent ural", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Allegany MD Lonaconing 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22300 Seldom Seen Road 21539 United States and Mental Hygiene.
is marked other than "natural", or items:
aumatic event, the Medical Examiner.mu should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1

X Yes 2 □ No WW 2 Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Tire Manufacturer Elementary/Seconday (0-12) unknown College (1-4 or 5+) Trucker Be 17. Father's Name (First, Middle, Last)
Phillip Vinci 18. Mother's Name (First, Middle, Maiden Surname) ೭ Ethel Swick 19a. Informant's Name/Relationship (Type, Print) Elizabeth Vinci/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22300 Seldom Seen Road, Lonaconing Maryland 21539 permit. Page 1 and 2.2...
Department of Health an Important: If item 27 is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Lonaconing Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Self inflicted gun shot wound to chest disease or condition resulting in death) 3000EA Medical Due to (or as a consequence of) Examiner Depression Sequentially list conditions. Examine If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1700 work? 8/21/10 Investigation
6 Could not be pt shot himself Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) outside deck, residence 22300 Seldom Scene Rd Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3/🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 8/23/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Snow, 124 W. 3rd St., Cumberland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 14, 2010^{eai} PM 1:40 Phullis Bonnie Warner Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care Potomac Potomac . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Mar. 16 New York Director 116-34-0442 68 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 703 Rolling Fields Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Modeling Agent Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Mazansky Herbert Berk Jeanne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Bethesda, Maryland 20817 Greg Warner, 5906 Maiden Lane. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gdns 8/16/2010 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signature of Funer 1 ervic M00705 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC LUNG CANCER TO BRAIN AND BONE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine dany, leading to immedicause. Enter Underlying Due to (or as a consequence of, the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year

Pnysician, Medical Examiner

signed by the a

page 2

certificate

hours after death.

neral Director: After this filled in by the funeral d

within 24 hours a To the Funeral I

npleted

þ

Completed

Certificate: To Be

Medical

25. Was case referred to medical

29b. Signature and title of certifier

AUG

2**X** No

5 Pending

Investigation Could not be

determined

1 🗌 Yes

27. Manner of Death

1 🛚 Natural

4 Homicide

29a. Certifier

(Check

Accident Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

within 72 hours after death

Maryland 21215-0036

Baltimore,

Pregnant at time of death

5 Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

Registrar's Signature

24a. Was an autopsy

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

performed? Yes 2 N 26. Place of Death (Check only one)

Other: 4 Mursing Home 5 Residence 6 Other (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 28d. Describe how injury occurred 1 🗌 Yes 2 🗆 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D31319

28h Time of

August 15, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bethesda, MD 20814 Albiol, M.D. 8218 Wisconsin Avenue, #305 Loreto S. 31. Date filed (Month, Day, Year)

State Registrar

- wage	Phy	sician	
1	Exa	edica iminei	
s, P.O. Box 68760,		igned by the attending physician and igned by the attending physician and igneral be detached for use as the burial-transit ignoration.	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

		For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			ene 2010	27401
		Decedent's Name (First, Middle,	Last)	-			2. Date of Death		3. Time of Death
Physicia /Medic		CURTIS	WENDELL	WIGGIN	S		AUG 12	2, P2010 Year	6:10 A. M.
Examin		4a. Facility Name (If not institution, HOSPICE OF TH.		z r	4b. City, Town, or			4c. County of Death	
- Francisco				e (In yrs. last birthday)	HARWOOD If Under 1 Year	MARYLA If Under 24 Hrs.	8. Date of Birth	ANNEARUNI 9. Birth	DE place (State or Foreign
Funeral Director		225-84-4893	4 TM 14 A T E	5.5 Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Cou	intry)
pu "		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	eation				10d. Inside City Limits
f sho	or	MARYLAND PRINCE	' GEORGE	MITCHELI					1 X Yes 2 □ No
r 28a-	Director	10e. Street and Number	GEORGE		10f. Zip Code			g. Citizen of What Cou	untry?
th with	al D	3304 MICHELE	LAND		20721		U	$I \cdot S \cdot A$.	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations in the rediffied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? d 1 Yes 2 N If Yes, Give Year or Dates:	Vo.	Was Decedent of Hi If Yes, specify Cubar 1 □Yes 2ሺ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Amer Black, White Specify: B L 2	, etc.
2 hour		15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	10	6b. Kind of Business/li	ndustry
thin 72 e. an "na Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	+)	kind of work done d DO NOT use retired,	uring most of work)			EVECTOR
ed wil	င္ပ	12	2	POLI	CEMAN			ETRO (LAW	ENFORCE
uld be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, La CHARLIE ELI W					e (First, Middle, Ma TOULSON	WIGGINS	
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exampone.		19a. Informant's Name/Relationship $BRIDGET$ ANN WI						City or Town, State, Z VILLE MD •	
es 1 a of He if item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	□ Removal from State	20b. Place of Dispo	sition (Name of matory or other place	9)	Date 26	Oc. Location - City or T	own, State
t. Pages tment of l tant: If ite		4☐Donation 5 ☐Other (Spe	cify)	HARMONY				ANDOVER M	ARYLAND
permit. Departr Importa any injt		21. Signature of Funeral Service Lie	Wach	I	2. Name and Addres 784 MARY			ADDY 305 LANC	22503 ASTER VA.
		23a. Part 1. Enter the di. ease, or co shock, or heart fail re. List or	omplications that caused ly one cause on each lin	e death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Fine disease or condition resulting in death)	_ a/	metasta	the pane	realice	cancer		1/2010
Examiner		, southing in down,	Due to (or as	a consequence of):					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury	b. Due to (or as a	a consequence of):					
ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
ficate physics the	dical		d						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
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ires tha signed	by P	Part II. Other significant condition	T.	•				acco use contribute to	
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Phys r this ral dir	<u>۽</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpatier	IL 3 L DOA	4 LI Nursing He	ome 5 Resider 28d. Describe how	nce 6 Other (Spec	cify)
nding F th. :: After e funera	atio l	1∠Natural 5 Pending 2 Accident Investigat	(Month, Day	v, Year) Injury	Work	? ′es 2 □ No	253. 250050	, injury cooning	
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	Certification: To	3 Suicide 6 Could not determine		ury - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
e Hospita 124 hours e Funera iletely fille	Medical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	f examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed (Month	
BBM		· MANG	my		1)5	3070		Aug 16,	2010
8		30. Name and address of person who DANIEL LAHERU.	M. D. BUNTIN	G BLAUSTETI	V CANCED DI	ESEARH RT.	D. 1650 OP	T.EANST BAT	21231 TIMORE MD.
Stat Registra	e	31. Date filed (Month, Day, Year) AUG 17	2010 32. Registra	ar's Signature	and .		2. 2000 OR.	LUMIN SI , LILL	
			- Comment	10. 19	D				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Keoshia W	right	1- For State	aryland / Depa Ce	artment of <i>rtificate of</i>		and	Mental	-	20	10 27402	
Physic	:ian/	1. Decedent's Name (First, Middle,Last)						2. Date of Dea		3. Time of Death	
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Funera		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under		If Under 24	Hrs. 8. Date of Bir		Birthplace (State or	
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. eath and Mental Hygiene. en 27 is marked other than "natural", or items 23a or 28a-f she fraumatic event, the Medical Examiner must be notified at once	<u>a</u>	2236 12th Place NW 11. Marital Status 12. Wa	as Decedent Ever in U	I.S. 13. Was	Decedent		009	(Specity Yes or No		States American Indian, Black,	
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21 hould hould Mel	P	19a. Informant's Name/Relationship (Type, Prir		9.1			nd Number	or Rural Route Nun	nber, City or Town,	State, Zip Code)	
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Division the Hospital or Attent hin 24 hours after death the Funeral Director: npletely filled in by the	Cert	4 Homicide determined (Sp	ecify) Local Stree	et				or Town, S S/B Marlboro		Place, District Heights, M	
Hos 24 h Fur	. –	29a. Certifier 1 Certifying Physician: To the one) 2 Medical Examiner: On the		-							
To the within To the comple	Medical	2	nner stated.	nd/or investigation		icense n		ed at the time, date			
	_	255. Signature and the order than				D.C.M.		OCME	August 11, 20	(Month, Day, Year)	
		30. Name and address of person who complete	d cause of death (Item	12321			<u>-</u> .		riaguot II, E		
2		Theodore M. King, Jr., MD. As	sistant Medical E	,	111 Penr	Stree	et, Baltim	ore, MD 21201			
5	state	31. Date filed (Month, Day Year)	32. Registrart Signat	te Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:09 P LINDA WERR AUGUST 15 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST. THOMAS MORE NURSING HOME HYATTSVILLE PRINCE GEORHE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 49 257-33-1240 IULY 31 1961 GEORGIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examinant hast be notified at 1 Yes 2 □ No Director MD PRINCE GEORGE'S FORESTVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or death with 2130 BROOKS DRIVE # 20747 Funeral items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XNo 0, Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>8</u> Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12TH CUSTOMER SERVICE PRIVATE marked other Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be GENERAL GRIER ELLEN BTYANT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 BROOKS DRIVE # 104 FORESTVILLE, MARYLAND 20747 CALVIN WEBB SR./HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) UNION CHURCH CEMETERY 8/21/2010 | MAYFIELD, GEORGIA 21 gnature of Fune 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part F. Edier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tra Cas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Interioscieno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mont ō Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to leath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy bage certificate Vital 1 ☐ Yes 2 (3No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 √o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 vursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Division of this 28a. Date of Injury (Month, Day, Year) After th funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Jepital c.
4 hours after dec.
-- reral Director; After 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after unitarial Direct
To the Funeral Direct determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Registrar
DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 16,2010 Year DONALD DECOVER WILLIAMS 1:30p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 Months Days Hours Country) Wash DC 1654-64-73E Director 74 579-46-8313 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Kyes 2 No Clinton Prince Georges Maryland 10f. Zip Code 10a, Citizen of What Country? Funeral 20735 AZU 8600 Mike Shapiro Drive , apt.1014 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ģ 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXIo Specify: Specify: Black Year or Dates 1973-75 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter **bth** Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Jessie Mae Matthews Price Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BLOD Mike Shapiro Drive # 810, Clinton, MD 20735 19a. Informant's Name/Relationship (Type, Print) Inez E. Williams / wife Important of He any injury or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) 08-53-5070 Beltsville, MD of Funeral 22. Name and Address of Facility Strickland Funeral Services, P.A. Allentown Rd, Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ iac ca. , Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed Yes 2 N Votre nospons. ...
within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pag. 2 🗌 No 1 🗀 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗹 No ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the Loat of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the Loads of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Cartifying Nurse Practioners to the best of my knowledge distribution, data and place, and due to the only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Wendell Pierson, MD, 7503 Surratts Road, Clinton, MD 20735 Wendell Pierson, MD

State Registrar 31. Date filed (Month, Day, Year,

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8 2010

DHMH 17 Rev 7/2009

Registrar

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JRSULA

2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #5,9,11,12,15,16A&b,17,18 &19a&b Per ANA BD G911 1/10/2011 jh State of Maryland / Department of Health and Mental Hygiene amend #19b&20a-c Per H G911 1/26/2011 JH 2011 2011 2011 2011 for State Registral Reg. N2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Month **Physician** July 28, 12:21 PM Richard J. Berquist /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel 96 Mary Land #101 Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 3, 1926 5. Social Security Numberante 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 ☑ M 2 □ F 84 **Director** 118-18-1616 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Anne Arundel Glen Burnie 1 ☐ Yes 2 TXNo Director 10f. Zip Code 21061 10g. Citizen of What Country? 10e. Street and Number 96 Mary Lane #101 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 110 L 1 X Yes 2 □ No If Yes, Give Year or Dates: 1943–45 11. Marital Status 1 ☐ Never Married 2 ☐ Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify. Specifiwh ite 2 ▼□ Widowed 4 □ Divorced Decedent's Usual Occupation Unit (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/IndustryUT 15. Decedent's Education (Specify only highest grade completed) Je filed ww.
*al Hygiene.
*ar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 1 and 2 should be filed wi Health and Mental Hygier sm 27 is marked other th Engraver Balto Sun Paper 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Thor Berquist Sadie Taylor traumatic ပ 19b. 23034 decress (Surect and Number or Bural Boute Number City or Town, State Zin Code) 2343 Wood Lawn Avenue Falls Church, VA 22042 8495 Veterans Highway; Millersville, MD 21108-1458 19a. Informant's Name/Relationship (Type. Print) Elizabeth Charles—niece Health a permit. Pages 1 and Department of Health Important; if Item 27 any injury or other tr. Anne Arundel Police 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9/08/2010 Catonsville,MD Metro Crematory Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 404 Kr 158AS Physician 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as 1 IF FEMALE: nse : fyes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Day ģ Month Vear 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? page 2 certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) eputy 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Nes 32. Registrar's Si State Registrar

DHMH 17 Rev 1/2001

		For State	icusc			nd / Depa	artmen	t of H	lealth		fental Hy	giene		07107
		Registrar 1. Decedent's Name (First, i	Middle, Las	st)		Cei	tificate	e of D	eath_		2. Date of Dea	Reg. No.	JIU	3. Time of Death
Physicia Medic		LAWRENCE D.	BLOOM	M, JR.		_					AUGUST	30,	20 ^{Yea} 0	3:35 A M
Examin	ier	4a. Facility Name (if not inst. GILCHRIST HO			nber)		4b. City, TOW		Location	of Death			unty of Death LTIMOR	E
Funeral Director		5. Social Security Number 079–30–8893	6. S	ex XM2DF	7. Age (In yrs. 71	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt SEPT . 2	9°°°193	9. Birth	place (State or Foreign try) NY
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Marylar 28a-f s otified	Director	MD	BALTI	IMORE		MIDDL	LE RIVER					1 ☐ Yes 2 🛣No		
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s after o ral", or Examin	Completed by	1 Never Married 2 Married 1 2 Yes 2 No If Yes, Give 1 Year or Dates.					1 🗆 Yes				moun, etc.,	Spe	Black, White, cify: WHI'	
72 hour	plete	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give						k done di	ation <i>uring m</i> os	at of worki	ng	16b. Kind	of Business Inc	dustry
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I be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, MicLAWRENCE D.		M, SR.							e (First, Middle, CHERINE			
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O			State GA	Place of Dispo cemetery, cren RDENS	sition <i>(Nam</i> natory or or OF FA	ne of ther place ITH	e)	9/3/) ate '10		on - City or To	
permit. Pepartm Departm Importa any inju		21. Signature of Funeral Service-Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, I 6415 BELAIR RD BALTIMORE, MD 21206								HOME, INC				
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To the within To the compl	Σ	29b. Signature and title of c		A O	AA	iy kilowieuge, t	290		pumber	1.7°		29d. Date si	gned (Month,	Day, Year)
71		30. Name and address of po	erson who	completed caus	e of death (Iter	n 23a) (Type, F	Print)	/ >	~ 1 1	200		TO SUL	21 20	2010
Stat	te	31. Date filed (Month, Day,	(ear)	177 V V V V 32. R	egistrar's Signa	V) 6	101 1	Α, (N	NIC	101	Jul	JUIV /	VV
Registra		SEP 0 1 2	010	Bened	1	back	/							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10c per file 907 9-1-10 vt 10c Maryland / Department of Health and Mental Hygiene D ITEM#1,4b,perPHYS,#11perFH,G907,9/16/10,WS Certificate of Death Reg. No. 27408 1. Decedent's Name (First, Middle, Last)

Daniel Edward Barclay Wheatley 2. Date of Death 3. Time of Death Physician/ Aug. 26°, 2010 Barclay, Jr. 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) Lity Town or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Sapita Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8, Date of Birth (Month, Day, Year) 02-24-62 Days Min. 48 Hours Director Yrs 220-80-6960 MD Usual Residence of Decedent 10a. State 10b. County Prince with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Georges 1 Yes 2X No Capital Heights **Clinton** 10e. Street and Number ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1816 Nova Avenue USA 20743 permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian,
Black, White, etc. African Armed Forces? Wever Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Electician Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Barclav Barbara Ann Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 4907 Goodnow Road Apt."A" Baltimore, MD Erika Baig-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cem. 09-03-10 4 ☐ Donation 5 ☐ Other (Specify) Anne Arundel Co.MD 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute upper Gastrointermine disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Esophagenl Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events Chrunic ALCOHAL abuse Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Records, Ang mich Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Sergure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy I schemic 5 more 1 ☐ Yes 2 ☐ No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 \(\subseteq \text{Yes} \) 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 50689 08/26/20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL K. MAHAJONMO. Sunthern tuspital center 7503 Sympties MD REGOT 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27409 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Sally Mae Boles 8:05 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA 724 Linnard Street Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birtip Country) NC 91 Months Hours 115-22-2946 0 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral with 1 21229 724 Linnard Street USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. African 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes Ž No Specify: If Yes. Give Specify: American 3 X Widowed 4 ☐ Divorced Year or Dates is marked other than "natur aumatic event, the Medical Sall 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than lury or other traumatic event, the M Elementary/Seconday (0-12) other homes Housekeeper 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ൧ Williams Dudlev Robinson Mattv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type, Print) 724 Linnard Street Baltimore, Maryland Garland Ingram-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If its 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or 09-08-10 Woodlawn Cem Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. any in 638 N. Street Baltimore, MD 21217 Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of) Examiner Secretially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) C bunal-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown the detached 9 | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RTENSION 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has Yes 2 XN 1 Yes 2 No this certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After work? 1 🛛 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kam S. Kan Inem 30

State Registrar

DHMH 17 Rev 7/2009

202 W. MAPLERI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D				and Mer			0 271.10
			Registrar 1. Decedent's Name (First, Middle, Last)	Certifica	te of L	Death		Date of Dea	Reg. N2 0 1	
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			Northwest Hospital		Rona	dails.	town			Himore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 1 M 2 🔀 F 98	rs. If Und Month	er 1 Year Days	If Under :		Date of Birth (Month Day, 9 2 3		Birthplace (State or Foreign Country)
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mo	Page lent or nt: If nt: If or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crown:	crematory or	other place		Date		20c. Location - City	
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760	death certificate be executed ne attending physician and ed for use as the burial-transi	edic	d							
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Bo	death	sicia	1 Yes 2 No 4 Pregnant at time of death	3 Ectopic 5 Other (s	pregnancy pecify)	′			Month	Day Year
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	after S after I Dire	Š	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factor	, office		28f. Lo	ocation (Stre lity or Town,	et and Number or State)	Rural Route Number,
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F	0 2 ≰ 5		29b. Signature and title of certifier		License r			29	d. Date signed (Mo	
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		- 1	Michael dewit Northwes	t Hasi	121	ER-	7			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygien Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 500 Month August Day Year **Physician** 10,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, 4c. County of Death Town, or Location of Death Examiner chdallstown 1050. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 56 Director 24 MD 214-62-7111 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at Baltimore Director MD NA Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 5317 Wesley Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after lopartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, It a Medical Examina 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Bar Assoc. Publications Asst. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Keene Floyd C. Ballard Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5317 Wesley Ave, Baltimore, Md 21207 Margaret Ballard-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/2010 Baltimore, Md On-Site 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part 1 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on elements. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** phyxia disease or condition resulting in death) /Medical Due le (or all a consequence of): **Examiner** lecis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as a consequence of) The law requires that the death certificate be executed burial-trar CERTIFICATION APPROVED BY MEDICAL resulting in death) Last Due to (or as a consequence of) physician sthe burial Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. ed by the ☐Yes 2☐No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform rmed2 2 No certificate 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2110 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Injury 5 ☐ Pending investigation Natural 2 Accident Fell off seat on bus 2005 1 ☐ Yes 2 X No Unknown M 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide bus on local street unknown Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title 1053850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RL LCR 31. Date filed (Month, Day, 2. Registrar's Sig State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23arti,23 per me,2907,09/01/2010dhb Reg. No. 1 - For A State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13-2010 Month Physician 10:114 Kodney /Medical 4c. County of Death 4a. Facility Name (If not intitution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 05-26-1945 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 65 285-38-5180 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2X No Director MD Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21014 300 Sunflower Drive Apt 343 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ☐ Yes 2 ▼ No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Crane Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cleona Miller Graydon A. Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3118 Cornwall Rd Dundalk, MD 21222 Shannon D. Rasel (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 08-18-2010 Bel Air, MD Mt. Zion Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arrhythmia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) CENTECATION NETWORD BY MEDICAL EARTH Examiner Hypertensive Atherosclerotic Cardiovascular Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) おがよし アメトロ MC Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ¶ Probably 4 ☐ Unknown 1 TYes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗌 No 2 🗌 No 1 TYes al or Attending Physician: Ts after death.
I Director, After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital: 1 Inpatient 2 NO Other: 2 ER/Outpatient 3 🗆 DOA 4 - Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 funeral 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 13, 2010 RES-000 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SUSAN DUAN 31. Date filed (Month, Day, Year) SEP 0 1 2010

32. Registrar's Signature

MD

parket

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$10b Per FH 6997 9/08/10 of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0.8**Physician** Year 5:10 PM Sherman L. Brown 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Raltimore tranklin Square Hospital ssedale Social Security Number 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral **№** M 2□ F Months Days Hours Min. 64 578-60-0159 Director 7-7-1946 ٧A Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hyglene. The marked other than "natural", or items 23a or 28a-f show the traumatic event, The Medical Exerciting to public and the returnatic event, The Medical Exerciting to the public of the control of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rd other than "natural", or items 23a or 28a-f shovevent, the Medical Exaction rough be notified at Harford Directo 1 □Yes 2 No MD Joppa Balto 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 433 MacIntosh Circle 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Harbor Hospital Clinical Engineer 12th grade Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morgan Brown ၉ Virginia Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. Linda Brown-Wife 433 Macintosh Circle Joppa, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Myerstown Cem Rippon, West, Va 4 ☐ Donation 5 ☐ Other (Specify) 9-3-2010 21. Signature of Funeral Stryice Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rrythm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🌌 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, P.O. s been signed by the should be detached Division of Vital Records, certificate has To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

มีกู เมต (Sherman Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, SEP 0 1 2010

29b. Signature and title of certifier

9000 Frank

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Square D

V16238

29d. Date signed (Month, Day, Year)

Raltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		rtment of H tificate of I		Mental H	ygiene 0	0	27414
	*	Ä	1. Decedent's Name (First, Middle, Las	t) a	1			2. Date of D		Vana	3. Time of Death
	Physic /Medi		Willie	Crawford	/			Jule/	29 a	Year	11:35 PM
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c. County	of Death	
			Future Care - Ho	mewood		Baltim	ore				
	Funeral Director		5. Social Security Number 6. Sr 216–20–5778	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	linh Day, Year) 1, 1927	9. Birthp Coul	place (State or Foreign ntryUNK
	p 2		Usual Residence of Decedent 10a. State 10b. County	100 Cib	y, Town or Loc	otice					0.1.1
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	Ne N	ecto	MD	ва	1timor						
	with I	급	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	eath	grai	723 W. 22nd Str		C 12.14	21218	i-Oriei-2	/C	USA		and lastic
36	within 72 hours atter death with the Maryland ene. than "neturel", or Iteme 23a or 28a-f ehow he Medical Examinar must be notified at	by Funeral Director	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify:	Blac	ek, White, :: White,		
ŏ	2 hou	ed	15. Decedent's Ed	16a. Deced	ent's Usual Occupa	ation unk		16b. Kind of Bu	isiness/în	dustryunk	
21215-0036	s within 72 liene.	Completed	(Specify only highest grader) Elementary/Secondary (0-12) unk		(Give I	kind of work done of O NOT use retired	lurina most of v	working			adon,
	ild be filed lental Hyg ked othe ild event,	To Be C	17. Father's Name (First, Middle, Last)	unk			18. Mother's N	Name (First, Middl	le, Maiden Surnam	θ)unk	
Maryland	nd 2 shou alth and M 27 le mer		19a. Informant's Name/Relationship (7 Artie Shaw – gua						ber, City or Town, Baltimor		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "neturel", or Iteme 23s or 28s-f ehow any Injury or other traumatic event, the Madical Examples must be notified at ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 📆 Qther (Specify	Removal from State	lace of Dispos emetery, crem	ition (Name of atory or other place	9)	Date	20c. Location -	City or To	own, State
Balti	permit. Departmingorts Imports any Inju		21. Si matri e di Figneral Syrvice Lice	ale, Director					tomy Boar ; Baltimo		MD 21201
	Physician /Medical		23a. Aart 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death one cause on each line. a. Carubra World Due to (or as a consequence)	en to	r the mode of dying	g, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
98760,	cate be executed by sician and burial-transit and and and and and and and and and and	dical Examiner	Sequentially list conditions, it my leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	ience of):						
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<u> </u>	hysle this c	၉	1 Yes 2 No		ER/Outpatient	3□ DOA Othe	T. 4 Nursing	Home 5□Res	sidence 6 Othe	er (Specif	y)
u	ding Pt h. After th funeral	on:	27. Marrier of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occurr	ed	
<u>si</u>	ttendi death. ctor: A / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				res 2□No				
Division	ospital or Attendents after deatlenders Director:	4 Homicide determined building, etc. (Specify)						City or To	(Street and Number own, State)		
	To the Hospital or Attending Physician: whim 24 hours after death as the feath To the Funerel Director: After this certification in the funeral director, completely filled in by the funeral director,	Medical	one) 2 Medical Exam	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inve	estigation, in my op	inion, death oc	ce, and due to the curred at the time	cause(s) and ma , date and place, a	nner as si and due to	tated. o the cause(s)
	with To com	2	29b. Signature and title of certifier	Solji		29c. License	7537		29d. Date signed	1 (Month, 2-3 -	
			30. Name and address of person who c	ALUMN 68	321 /16	cisters lo	mtg	Bult	M):	2_12	-15
	Sta Registr	_	SEP 0 1 2010	2. Registrar's Signar	ure fau	W					

Expired: July 29, 2010 - 11:35 PM

Crawford, Willie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Eleanor Cole August 24 12:55 A^{M} 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Glen Meadows Health Care Center Baltimore Glen Arm If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-22-5587 89 Jan 23, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Baltimore Glen Arm 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify: White Specify: 3- Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurse healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson Rutherford Alice Cale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 946 E. Piney Hill Road; Monkton, MD 21111 Karen Cole - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Service Rona d 22. Name and Address of FacilityState Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) FAILURE 07 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that is listed as a second control of the cause of Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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Medical Certification: To

Funeral

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	C. Due to (or as a consec	mence of).			
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F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
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7. Manner of De <i>a</i> th 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe he	ow injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ry, office	28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurrention and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the courred at the time, of	cause(s) and manner as stated. date and place, and due to the cause(s)
Oh Signature with of cortifior		2	Oo License number		201 Data diseased (Manufic Day 16 and

SF.

STE 4105

State Registrar

Susan 31. Date filed (Month, Day, Year)
SEP 0 1 2010

30. Name and address of person who completed

ANDHOR

N. CHARKES

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27416 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08-26-20 Po Betty Lou Cavey 1335 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) MD 8. Date of Birth 1 M 2 1 F Months Days Hours Min. 7-05-1929 Director 216-24-7553 81 Usual Residence of Decedent or 28a-f shov e notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1200 Marywood Drive 21014 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Thomas J Cavey & Sons Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Insurance Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Milton Webster Sr Captola Burnett ift. Page 1 and 2 shours out of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis B. Cavey (Husband) 1200 Marywood Dr Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 08-30-2010 Parkville, MD 22. Name and Address of Facility Schimunek Funeral Home of Signature of Funeral Service Licenses stuko Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) ommuni1 dau< Medical Examiner Sacruar tindly list exception on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Funeral Director, After this certificate has been signed by the attending physici. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be e of Injury - At home, farm, street, factory, office builting, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined e Funeral F Medical Certifying Physician: To the beat of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On Certify within 2 only one) ing Nurse Prayliner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:40A[™] Irene Crabtree August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Lutherville 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min (Month, Day, Year) 01/09/1943 Country) Maryland **Director** 216-40-3065 67 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9-C Norham Court 21221 U.S.A. Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Taxi Driver Transportation Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o Theodore Argyle Crabtree Dorothy Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cooper / Daughter 1606 Four George's Ct. Apt. B-3, Dundalk, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 09/01/2010 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, **complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on **ne cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ UTERINE CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 XNo 3 🗆 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No ျင Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Natural
Accident
Suicide 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30

DHMH 17 Rev 7/2009

State Registrar

11:40

AUGUST

CRABTREE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and acuress of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{Day} Auq. 2230 2018 Bernice C. Clipper Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F 216-40-7856 Days Hours March Day Director 84 1926 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Montgomery 1 ☐ Yes 2 No Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 0420 Beallsville Road 20842 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ò 1 Never Married 2 Married Black, White, etc δ 1 ☐ Yes If Yes, Give С. *СыРРЕ*Р. Диби Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Oscar Turner Lummie Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne C. Thomas/Daughter 20420 Beallsville Road Dickerson, MD 20842 Baltimore, ZERNICE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Boyds, Maryland St.Marks U.M Church Cem. 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 3a. Part 1. nter the e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart failu Immediate Cause Final disease or condition resulting in death) ARRHYTHMIA Physician, ARDIAC Medical Due to (or as a consequence of) Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is titled as each of the cause of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit <u> PULMONARY</u> STAGE that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy
performed?

1 Ves 2 No **Director:** After this certificated in by the funeral director, pag 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined hours after within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nur onnumed at the time, date and place, and due to the cause(s) and mainer as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 26 DO062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELSAYYAD 20850 10110 MOLECULAR DRIVE ROCKVILLE MARYLAND Registrar 1 State Registrar

DHMH 17 Rev 7/2009

Examiner Physician: The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, or Attending Japital C.
4 hours after dec.
real Director; After

Physician

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

12 should be filed with and Mental Hygier 7 Is marked other th

Health a

permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other

Physician

/Medical

physician and s the burial-trans

attending ph for use as the

cate has been signed by page 2 should be detacl

certificate

After this certification, I

24 hours a Funeral L Hospital

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completely

Baltimore, Maryland 21215-0036

/Medical

10a State

MD

Director

Funeral

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Completed

Be

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to literate in the cause of the Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058965 Saima Khamayn AUGUST 24th 2010

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1801

PARKVILLE

WENTWORTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death ounty of Death 2asons Andells TWW. CTIVIN Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F (Month, Day, Year 931 Days Hours Months Min. **Director** 218-26-7923 79 Mary Tand Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 5361 10f. Zip Code 10g. Citizen of What Country? Fundinal 21215 **USA** Cordelia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No If Yes Give Specify. Specify: Black 3[™] Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper 8th grade Private Industry To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James S. Carter Catherine Rainkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 Clarinth Road #D2 Baltimore, MD 21215 Rainelle V. Royal/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 09/0772010 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cem. Owings Mills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death n signed by the a Id be detached fo 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings avallable prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Spec Hospital Die မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Aatural injury 5 Pending ithin 24 hours after death.

the Funeral Director: A smpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d, Date signed (Month, Day, Year) 08 201 23a) (Type, Print) 30. Name and address of pers who complet se of de th (Ite 31. Date filed (Month, Day, Year) . Realstrar's Si State SEP 0 1 2010 Registrar

DHMH 17 Rev 7/2009

			Registrar		tificate of			No.2010	27421
J	Physici /Medi		1. Decedent's Name (First, Middle, Last) Imelda	Zanella	deLeon		Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) FRANKLIN SQUCTE HOSPET	cel	205	r Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number N/A 6. Sex 1 □ M 2 1 F 7. Age (In 45) Usual Residence of Decedent	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye 05/25/1	9. Birth 966	place (State or Foreign ntry) Mexico
)	a-f show	ctor		. City, Town or Loca		ındalk		1	10d. Inside City Limits 1 XYes 2 No
, ,	23a or 28	ral Director	10e. Street and Number 7925 Trapple Road, Ap	t. D	10f. Zip Code	1222	10g.	Citizen of What Cour Mexic	
0036	72 nouts aner death with the Maryland Inatural", or items 23a or 28a-f show dieal Exeminat must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever i Armed Forces? 1 □ Yes M□ No If Yes, Give Year or Dates:	lf'		lispanic Origin? (Speci an, Mexican, Puerto Ri Specify: Mexi		14. Race - Americ Black, White, Specify: W	
3 ريا (within 72 n lene. than "natu I n Malica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decede (Give ki	nt's Usual Occup nd of work done of NOT use retired	ation during most of working t)	165	. Kind of Business/In	dustry
	Hygien Hygien other th	Con	12 17. Father's Name (First, Middle, Last)		Prep C	look 18. Mother's Name (F	First Middle Main	Restaura	int
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	m 27 is m m 27 is m		19a. Informant's Name/Relationship (Type. Print) Zanella Adrian/Brother	7831	E. Col		Route Number, Ci	ity or Town, State, Zip ot. B, Du	ndalk, MI
Baltimore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, If it Medical once.		4 □ Donation 5 □ Other (Specify)		rney Cre	em. 9/2/20	010	Location - City or To Noodbine, M	D
Bal	Depar Impor any In		21. Signature of Funeral Service Lionsee Porota Mar	shall 22.	Name and Address Mary Porba	s of Facility Land 4C3,	ation Baitim	Servines	1203
E:	hysician and fine prival-transit the prival-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Subaca Condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution) Due to (or as a constitution) Due to (or as a constitution)	sequence of): A CETE Sequence of):	hemo	orrhag e	٤		Approximate Interval Between Onset and Death
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed	red by the attending physicial detached for use as the buri	Physician/Medical E	d	etal death 3 🗆 E	ectopic pregnancy	1	_	23d. Date of delive	ery Day Year
rds, F quires that	on signed tuild be deta	፩	Part II. Other significant conditions contributing to death but not	resulting in the und	erlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
of Vital Records, Physician: The law requires t	certificate has been s ector, page 2 should	Completed					24a. Was an autopsy performed 1 □Yes 2 ☑	prior to cor death?	psy findings available mpletion of cause of 2 □ No
f Vity	this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Fes 2 ☐ No Hospital: 1 ☐ Inputient 2	ER/Outpatient	3 DOA Othe	26. Place of Death (C		e 6 □Other (Specifi	
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amenda and Jype or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 27423 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 8 2:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore Hmore 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth Funeral (Month, Day, Ye 1 ☑ M 2 ☐ F Months Days Hours Min **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f sho important: If then 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timure 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap-Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced 3/ac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Olife. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, ၉ MANO 7 dress (Street and Ny 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Che 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State pemetery, crematory or other pl 4 ☐ Donation 5 ☐ Other (Specify) 2010 OUn Signature of Funeral Service Licensee an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Atheroscle Medical resulting in death) Due to (or as a consequence of) Examiner Securities list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last PmI P Oic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 ₁ ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 14 No Other: 욘 1 TYes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury Accident 5 Pending 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, year occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatui and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year MILLARD ECKloff August 2010 4:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayvien Medical Johns Hopkins Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Month, Day, July 14 214-26-3799 Director 80 1930 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 South Decker Avenue 21224 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 √Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Millard F. Eckloff Sr. Laura Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Richardson Granddaughter 3516 Balmar Mews, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August cemetery, crematory or other place) 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Bayview Crematroy 2010 ture of Juneral Service 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, p.A.
7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ pulmonary ardio arrest disease or condition holus Medical resulting in death) Examiner 2 weeks Intracrania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death?
1 Yes 2 No performed? Yes 2 No **Director:** After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 잍 4 Nursing Home 5 Residence 6 Other (Specify 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural 2 Accident 3 Suicide work?
1 Yes 2 No 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 MD August 28 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Bang, MD 4940 21224 MD Eastern 31. Date filed (Month, Day, Year) **SEP 0 1 2010** 32. Registrar State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

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cal ner	4a. Facility Name (if not in	stitution, give	street and number)		4b.	City, Town, or Lo	ocation of Death		4c.	County of I	Death
	VA MANUA MAN	r 6. S	th CARL Sy	Skm ge (In yrs. last b	birthday) If U		oint If Under 24 Hrs.	8. Date of Bi		<u>Ceci</u>	. Birthplace (State or Fore
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Director	10e. Street and Number			<u> </u>	10	of. Zip Code			10g. Cit	izen of Wha	1 1 Yes 2 □
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	19a. Informant's Name/R Deborah Ri			1	19b. Mailing Add 1 4 5 N	dress (Street and Lynb	nook F	ral Route Numb Road , E	er, City or Be I	Town, State Air,	MD 21014
	20a. Method of Dispositio		Removal from State		e of Disposition etery, crematory	(Name of or other place)		Date	l		y or Town, State
	4 Donation 5 21. Signature of Funeral S		200		22 Non	ney Crem		2010	Wo	odbine	e, MD
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Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Division of Vital Records, P.O. Box 68760

signed by the atte page 2 should the funeral director,

Physician/

Medical

10a. State

Md.

Examiner

Funeral

Director

or 28a-f show

must be notified at

ral", or items 23a Examiner must be

"natural", or

traumatic event, the Medical

or other

other

Mental Hygiene.

permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked

Pnysician/

Medical

Examine

Physician/Medical

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Completed

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Certificate:

IF FEMALE:

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

faill	ire, cor
25. Was case referre examiner? 1 Yes 2	/
27. Manner of Death	
1 Natural 2 Accident	5 Pending
3 Suicide	Investigation 6 Could not be
4 Homicide	determined

28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
i, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier RDimaano, MD	29c. License number 00065809	29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 8/27/30/0					

Rivinaano	PID
20 Name and address of parson who complet	ad cause of death (Itam 23a) (Time Dring

Rhett Gerard		
	32. Registrar's Signature	

State Registrar



28e. Place of Injury - At home, farm, stree building, etc. (Specify)

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 28 2010 6:25 PM **FEDDER** DONALD 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** X M 2 D F Days Hours 1172071926 **Director** MD 212-28-9230 83 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 EAST LEE STREET, APT. #907 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: nd Mental Hygiene. marked other than "natural", WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** 5+ **PROFESSOR** Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ပ **FEDDER** ROSE **FEDDER** WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EAST LEE STREET, APT. #907, BALTIMORE, MD 21202 MICHAELINE FEDDER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 08/31/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ procreatic worth а Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical certificate be use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed Nc page certificate 2 No ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 27 Other: 1 Yes 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: al or Attending P s after death. I Director; After t 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 145356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Records,

of Vital

Division

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Raymond 2:26 PM Louis Green Medical ugust 2010 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Min. 11/27 Hours 217-26-9867 **Director** 77. Yrs 1932 Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e, Street and Numbe 10g. Citizen of What Country? items 23a Funeral 4010 Derby Manor Drive 21215 U.S.A death v 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 'natural", or þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk year Postal Service Be Department of Health and Mental H Important If item 27 is marked ott any injury or other transcoone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Louis Green Sr. Flossie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Green(wife) 4010 Derby Manor Dr., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. 09/02/10 Baltimore, MD Signature of Funeral Service Licensee 20140 N. Fulton Ave: , Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Onset and Death Sevel disease or condition ino H Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 L retail usu Pregnant at time of death in the past 12 months? Month Day Year 2 No g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tes Other: 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date

and title of certifie

filed (Month, Day,

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of person who completed cause of death (Item 23a) (Type, Print) 201

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ε. Month Mary Gangi 2010 August 7:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D Hours July 28, 1919 **Director** Maryland 220-03-2398 Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Lutherville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Othoridge Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Contract Administrator State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Pietro Borghese Sababtrina Tringali permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Jinno-daughter 4510 Mainfield Ave., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 9/3/10 Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral 21. Signature of Funeral Service Licensee Dau 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as sonsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕽 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas e 2 s autopsy ar this certificate has eral director, page 2 2 🗌 No Yes 2 No 1 Tes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) MD 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20⁴0 Thomasine 7:50 Margaret Gradv August Medical а 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Villa Assumpta Baltimore **Baltimore** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, 1 □ M 2 🔀 Months Days Hours Min 065-42-8266 Director 87 Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "...-any injury or other than "...-10b. County 10a. State 10c. City, Town or Location Director 10d, Inside City Limits Md. Baltimore Stevenson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1531 Greenspring Valley Rd. 21153 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Joseph Grady Margaret Ann Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Patricia Hoeflich S.N.D. 1531 Greenspring Valley Rd. Stevenson, Md. 21153 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 9-1-2010 Sisters of Notre Dame 4 Donation 5 Other (Specify) Ellicott City, Md. Signature of Fiveral Sev ice Lice Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. York Rd. Towson. 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MONTH Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nolesterolemi 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has har ral director, page 2 s autopsy perform 1 Yes 2 No Yes 2 N Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 Accident
3 Suicide 2 🗌 No Investigation Director: 6 Could not be thin 24 hours after de the Funeral Directo ompleted filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifie crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only on 29b. Sighatı and title of certifier 29c, License number

State Registrar

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address of person who completed cause of death (Item 23a) (Type,

filed (Month, Dav.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Hi 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Ctr. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X 0 2 0 F Months Days 570-60-1770 6 / 25 / 1 9 4 5 65 Yrs Director CA Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 312 Pintail Lane 21409 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2X Married 1 XYes 2 □ No Army If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 <u>Project Manager</u> Construction Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Dolph Hill Christine Christensen Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Rebecca S. Hill/Spouse 312 Pintail Lane, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 8/30/2010 Woodbine, MD Signature of Funeral Service Licensee Dorota Marshall ess of Facility Maryland Cremation Services 1413. Box Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death rog ressive Physician Medical resulting in death) Due to (s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached the 9 Unknown þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Danpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 4 hours after death.

uneral Director: After the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 8

Registrar

State

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State of Maryland / Department of Health and Mental Hygiene 2010

			for State Registrar	oldio of Mary		rtificate of	Death		eg. No.		true (f	=7 U 6
			1. Decedent's Name (First, Middle, L	ast)	· · · · · · · · · · · · · · · · · · ·			2. Date of Deat	h	V	3. Time o	f Death
Physician /Medical Examiner			Dwight Lee Hartman					August			9:00	АМ
			4a. Facility Name (If not institution, g	·		1	r Location of Death		4c. County			
100			15 Fox Fire Driv			Port De	-		Ceci			
	Funeral Director	015 40 0006 1XM 2 5 6 7 3				If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, July 30	, Year) 943	9. Birthr	place (State	o <i>r Foreig</i> n
	and w	1	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside C	ity Limits
	Aaryla f sho	5	MD Cecil		Port Dep							2 X No
	the 28a	rect	10e, Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Cour	ntrv?	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examination to invitind at	by Funeral Director	15 Fox Fire Dr			21904			USA			
	item item	Ë	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	ean Indian, etc.	
036	ours aff	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Vac Giva	1964	1 □Yes 21∑No	Specify:		Specify	whit	е	
5-0	72 hc 'natu	etec	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. Dece	dent's Usual Occup	oation UN during most of work d)	ing I	16b. Kind of Bu	usiness/In	dustry un	6-5
2121	y within giene. rr than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retired	d)					
2	al Hy other vent,	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name			ne)		
ylai	ould b Ment arked atic e	일	Floyd Hartman				Thelma	Francis	Miller			
, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exanciant countries any once.		19a. Informant's Name/Relationship Ann Hartman -		19b. Mailii 15	ng Address <i>(Street</i> Fox Fire	and Number or Rur Dr; Port	al Route Number Deposit	City or Town, Mary	State, Zip Land	Code) 21904	
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Spec	Removal from State	0b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	ce)	Date	20c. Location -	City or To	wn, State	
Balt			21. Signature of Funeral Service Lice Ronald S	nsee die Direc	ter 2		ss of Facility Sta altimore		_		MD 21	201
			23a. Nort 1. Enter the discase, or cor	nplications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approxima Interval Be	te
-	Physician		s ck, or heart failure. List only Immedia: Lause (Final disease or condition	one cause on each line.	Comme	GIO CAN					Onset and	Death
	/Medical		resulting in death)	Due to (or as a co		CIO CAIC	cinome					
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a con	nsequence of):							
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687	rtificate ng phys as the	Medical		d								
Вох	ath ce attendi for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnanc	у			te of deliventh	-	Year
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σ.	that ned b		Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use cont	ribute to t	ne cause of	death?
rds	quires t n signi	d by						1 □ Ye	s 2 No	3 ☐ Prob	ably 4 🗌	Unknown
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24a. Was a a autop performed a summer? 25 Was case referred to medical examiner? 25 Was case referred to medical examiner? 26 Place of Death (Check only or both check						autops perforn 1 🗆 Yes 2	y ned?	prior to completion of cause of death?				
/ita	Physician: T r this certificat ral director, pa	Be (25. Was case referred to medical examiner?				26. Place of Deat					
of \	Physi this c		1 ☐ Yes 2 ☑ No		2 ER/Outpatier		4 LI Nursing Ho	me 5. Reside			y)	
Division	ing After une	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Yea n	28b. Time of Injury	Worl	y at k? Yes 2 □ No	28d. Describe ho	w injury occurr	ccurred		
Visi	Attend ir death. ector: / by the fi	ifica	2 Accident 2 Accident 2 Accident 2 Accident 2 Accident 3 Suicide 6 Could not be determined 4 Description 4 Descrip						ber or Rural Route Number,			
٥	ital or irs afte ral Din	Cert	4 Hornicide	building, etc. (5)				City or Town				
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	h occurred at the til vestigation, in my c	me, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and ma ate and place,	anner as s and due to	tated. the cause(s)
_	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	100	Physizzo	29c. Licens	e number	29	9d. Date signed	d (Month,	Day, Year)	
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			30. Name and address of person who	((Item 23a) (Type,	Print) Un	OU ENSITY	of to	syland	1		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	mnature 🌶	22 5. 0	LEENE "	- Be	MONTEN		MO 2	1201
	Sta Registr		SEP 0 1 2010	Sewer &	park							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Holt Month 20 19 0 10.39 AM 90 1114 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard County General Hospital Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Min OCt 21 Months Director 214-44-3982 75 Mary land Usual Residence of Decedent Show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗆 Yes 2 ื No Maryland |Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3680 Mount Ida Drive Apt. C 21043 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) mentary/Seconday (0-12) College (1-4 or 5+) 10th grade Domestic Engineer Private Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Rebecca Richardson William T. Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |6402 Walnut Street Baltimore,MD 21207 Mable Hawkes/Sister 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 9/06/2010 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Woodlawn, MD Signature of Fan Service Lie 22. Name and Address of Facility Chatman—Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 Part 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Onset and Death Imme The Cause (Final Physician/ YOCA Medica: resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autop performed 2 No 2 🗌 No 1 Yes ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tyes 2 LZ No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this countries at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10027718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Registrar
DHMH 17 Rev 7/2009

State

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Frank Norman Hoffman, Jr. 2010 6:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care, Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 220-74-9833 1 🔀 M 2 🗆 F Months Hours 78 Mary Land Director Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1813 Thornbury Road 21209 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 x Never Married 2 ☐ Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Disabled event, the 12 should be filed watth and Mental Hygi 27 is marked other r traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Frank Norman Hoffman, Sr. Bertha A. Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Gene Hoffman Brother 620 Barnes Ave. Westminster, MD 21157 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or Mt. Olivet Cemetery : Sept. 3, 2010 Frederick, MD Donation 5 ☐ Other (Specify) Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

22. Name and Address of Facility

Burrier-Queen Funeral Home & Crematory, PA

1212 W. Old Liberty Road Sykesville, MD

21784

Approximate 21. Sign tu edi de Cause (Final Onset and Death Physician/ di a or condition resulting in death) defectiveme Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 A Other (Specify) To O 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) all scarp R125 808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charles of anuc VA CRNT 10f ex 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 4:15 PM August 2010 Lucille Hartsock Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 102 Baltimore St. Aberdeen Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min 224-56-3856 67 Director Maryland Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Harford or 28a-f Maryland Aberdeen 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 102 Baltimore St. 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 9 Black, White, etc. 1 Never Married 2 X Married Completed by Specify: White 1 ☐ Yes 2 X No Specify: "natural", If Yes. Give 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Appraising Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William R. Gompers Betty A. Stapks . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Baltimore St, Aberdeen, MD 21001 Bud Hartsock / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 9/3/2010 cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aberdeen Harford Memorial Gdns 21. Signature of Funeral Service Licensee Z2 Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
222 C Darke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or iinjury that initiated events Due to for as a consequence of, attending physician and for use as the burial-transil Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month Day Year 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signage 2 should b Completed 1X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 2 No Yes 2 X 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Montha 12:15p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗗 F 10778/1926 Months Hours Director 099-20-1405 83 Maryland Usual Residence of Decedent ural", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD N/A 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral FairmountAve. 2721 W. 21223 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Dietary MD General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည injury or other traumatic unk Willie Minter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jefferson(husband) 2721 W. FairmountAve., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State Anderry crematory or other place) 09/01/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 27 Treephidren of Fabrown Jr. FUneral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, 1Cm disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 216 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifier 29d. Date signed (Month. Day. Year) MD. 125 08 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBIR R P LIS, MD 419 We Redwood # 420 MD 21201 West 31. Date filed (Month, Day, Year) SEP U 1 2010 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23aPtII, 25 pe me, g907, 09701/2010dhb

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 27437 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Marie Gibson Kay 7:30 A M August 18 y 2016 ar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏝 Months Days 87 Hours Min September 7, 1922 South Carolina 248-28-0687 Director Usual Residence of Decedent 10b. County at 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f st notified Gaithersburg Maryland | Montgomery 1X Yes 2 ☐ No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 804 Pheasant Run Drive 20878 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 \ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 6b. Kind of Business Industry Electrical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Firm 12 Project Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Admer Leroy Gibson Evelyn Henry Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9740 Ambergate Court, Gaithersburg, Maryland 20882 Lynn Weber/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomer vor or other place) Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State rium, Inc. 08/21/2010 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License M01498 23a. Part 1. Defer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shoc 2 Drobable Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year signed by the PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Infarction 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? ျှ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of contifier 29dA Date signed (Month, Day, Year) 2010 VO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN DOLINSKY RUSSELL WD 911 AVENUE GAITHERSBURG MARYLAND 20879

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

07:30

AUGUST 12, 2010

GIBSON

MARIE

32. Pégistrar's Signature,

10-06497
Kenneth Kerr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Kerr		S 1- For State Registrar	tate of Maryla		artment o e <i>rtificate d</i>		and Me	ental Hy		20 Reg. No.	10 2743
Physicia Medical Examir		Decedent's Name (First, Mid-		err					2. Date of De Month August 2	ath	3. Time of Death 1201 hrs
		4a. Facility Name (if not institut Franklin Square ICU	on, give street and nu	mber)		4b. City, Town, Rosedale		on of Death		4c. County of	
Funeral Director		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Y	$\overline{}$	Inder 24Hrs.	8. Date of B	irth(MM/DD/YYYY)	Birthplace (State or Foreign
Director		212-72-9129 Usual Residence of Decedent	1 X M 2 F	4	6 Yı		dys The	July IVIII I.	08/3	1/1963	country) Maryland
wany		10a. State 10b. County		10c. City	y, Town or Loca	tion					10d. Inside City Limits
aryland 8a-f sho at once	Director	MD Balt 10e. Street and Number	imore	Es	ssex	10f. Zip Code)			10g. Citizen of Wha	1 Yes 2 No
h the Man and 3a or 2	Dire	15 S. Marlyn A	Ave., Apt.	В		2122	L			U.S.A.	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	farried Armed Fo	2 X No		as Decedent of Yes, specify Cut	an, Mexic	can, Puerto		White,	
ours after	اھ	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grad			Yes 2 X	pation (Gi	ve kind of w		Specify: 16b. Kind of Busi	White iness/Industry
36 in 72 hc han "ns lical Ex	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)		nost of working I			ed)		
5-00; led with Tygiene other ti		17. Father's Name (First, Middle	, Last)		T.eTeA:	sion Te			(First, Middle,	ELect Maiden Surname)	ronics
2121 ild be fil Mental I narked event,	To Be	Marion The 19a. Informant's Name/Relation:	OMAS	Kerr	19h Mailin	a Address (St		ith	Ann Ural Pauta Nur	Ame mber, City or Town,	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than n aumatic event, the Medica		Blaze Kerr / S			7803	St. Bo	nifa			ltimore,	MD 21222
Ges lan tof Hear trepther tr		20a. Method of Disposition 1 Burial 2 Crematio			Place of Dispo crematory or o		cemetery,		Date		City or Town, State
Baltimore, permit. Pages ar Department of Hee Important: If ite	ŀ	4 X Donation 5 Other S 21. Signature of Juneral Services	pecific Licensee	Ana	atany Gif	ts Regist	ss of Fac	08/	31/2010	Hanover ifts Regi	, Maryland
の ^製 点 点 道 Physician	4	23a. Part I. Enter the disease of	complications that ca	used the death	175	22 Conn	elle	v Dr.	Ste.	P. Hanove	er. MD 21076
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	ren each line.		Hemorr		g, odori di	o caratac or	respiratory an	est, shock, of fleah	Between Onset and Death
Zammer		or condition resulting in death)	Due to (or as a or	- 7		vascula	r Di	sease			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause	Due to (or as a								
cuted nd ransit	edical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence o	of):						
to, te be executed ysician and burial - transit	edica	X UNPENDED	AMENDED	23a,b,2	27 per i	ne g908	10-1	3-10	vt		
ox 6876 ath certificat attending ph or use as the	sician/	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?) 1 Yes 2 No 9 Uni	ne 1 Live bir	nt at time of de	2 Fe	tal death 3 her <i>(Specify)</i>	Ecto	pic pregnan	су	23d. Date of de Month	elivery Day Year
that the or	by Phy	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	inderlying cause	given in	Part I.			ute to the cause of death?
ords, P.C. w requires that us been signed is should be deta					<u>-</u>				1 Yes		Probably 4 Unknown ere autopsy findings available
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rape death. The Director: After this certificate has been signed by lited in by the funeral director, page 2 should be detactive.	Completed								autop	psy prio rmed? dea	or to completion of cause of ath? Yes 2 No
Vital Rec	8	25. Was case referred to medica examiner?	Hospital: 1 🖊 Inj		ER/Outpatient		Other	th (Check or			
ion of Vi tending Physi eath. tor: After this the funeral dir	의	1 Yes 2 No 27. Manner of Death	28a. Date of	f Injury	28b. Time of I		ury at Wo			Residence 6	Other:
ivision or Attendi after death. Director:	catio		stigation	of Injury - At h	ome, farm, stree		Yes 2		POF Lagation /5	Street and N. mb.	or Rural Route Number, City
Divis	Certification:	4 Homicide deter	d not be mined (Specify)	Orinjury Acris	onie, iaim, sirei	st, lactory, office	bullding,	etc.	or Town, S		or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	<u>ख</u>		nysician: To the best	examination a							
F F F S	E	29b. Signature and title of certifie	and manner sta	led.		29c, Licer		er -			(Month, Day, Year)
	-	30. Name and address of person	who completed cause	of death (Item	23a)	0.0	.M.E.			August 29, 2	010
B		Donna M. Vincenti, Mi	O Assistant Me	edical Exan	niner 111	Penn Stree	t, Baltin	nore, MD	21201		
Sta Registra	te :	31. Date filed (Month, SEPa	1 2010 32. Re	strar's Signatu	ire /	and I					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kizzy Leemore		S 1- For State Registrar	State of Maryla		artment of ertificate of		nd Mental	l Hygiene	20	10 2743				
Physic		1. Decedent's Name (First, Mide	dle,Last)					2. Date of D		3. Time of Death				
Medical Exam	iinei	Kizzy De 4a. Facility Name (if not instituti	enise L	eemore					19, 2010 Year	1/26 hrs				
		St. Agnes Hospital	on, give street and nor	mber)	1	4b. City, Town, o Baltimore	or Location of D	eath	4c. County of N/A	f Death				
Funera		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Ye	ar If Under 24	4Hrs. 8. Date of		Birthplace (State or				
Director		unk	1 M 2 F	30) Yrs.	Months Day	ys Hours	Min.	3/1979	Foreign Country) MD				
ny .		Usual Residence of Decedent 10a. State 10b. County		Inc. Cit.	y, Town or Location				37.12.2					
Maryland 28a-f show any d at once.	<u> </u>	MD Tob. County				.on				10d. Inside City Limits 1 X Yes 2 No				
11215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygene. narked other than "natural", or items 23a or 28a-f shoevert, the Medical Examiner must be notified at once.	Director	10e. Street and Number		Dall	imore	10f. Zip Code			10g. Citizen of Wha					
the M	Dir	3430 Spellm	an Road		1	21225				•				
th with	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	J.S. 13. War	L is Decedent of Hi es, specify Cubai	ispanic Origin?	(Specify Yes or N		American Indian, Black,				
er deaí	Ē		Married Armed For 1 Yes ivorced If Yes, Give Year	2 🗶 No				erto racan, etc.,	White,					
urs aft itural' aming	d b	15. Decedent's Education (Spe	or Dates:		16a. Decedent	Yes 2 X No t's Usual Occupa	ation (Give kind	of work done	Specify: B	Black iness/Industry				
6 172 ho an "na cal Ex	Completed	Elementary/Secondary (0-12)			during me	ost of working life	DO NOT use	retired)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
within giene.	dmo	11th Grade 17. Father's Name (First, Middle			unem	ployed	Libra	ry aid	n/a					
215- e filed tal Hyg ked otl	Be	Eugene Ellis	. ,	= - <u>-</u>		1	18.Mother's Na	ame (First, Middle	, Maiden Surname)					
	To B	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree	<u>Mary</u> et and Number	Jean J or Rural Route Ni	Leemore umber, City or Town,	, State, Zip Code)				
E p d d m		Lora Leemore	e(sister)		503 1	N. Stre	eener	StBal	ltimore	MD 21205				
E E E		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fro	20b. Form State	Place of Disposit crematory or oth GSADI EM			Date	20c. Location - C	City or Town, State				
Baltimc permit. Page Department of Important: injury or ott		4 Donation 5 Other S	Specify:	And		_		unk	Balti	more,MD				
Bal permi Depar Impo injur		21. Signature of Funeral Service	Signature of Funeral Service Licensee 2140 N Fulton Ave., Baltimore, MD											
Physician	- 1	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart Applications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart and the caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart and the death Do not enter the disease.												
/Medical Examiner		Immediate Cause (Final disease	congen:	ital sp	inal co renal d	rd anoma	aly sur	gery com	plicated	by Between Onset and Death				
		or condition resulting in death)	Due to (or as a c	consequence of	f):									
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of	r():									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of	nf):									
cuted and transit		Overro resulting in country	d											
0, be executed sician and ourial - transi	edical	X UNPENDED	X AMENDED 10	b-f.perF	h.G907.9/	1/10.WS 2	3a,27,8	3915 5-17	7-11 sm					
Box 68760 death certificate be the attending physical	n/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, ou	utcome of pregn	nancy	al death 3	Ectopic preg		23d. Date of de Month					
x 6 ath cert attendii	sicia	past 12 months? 1 Yes 2 No 9 ✓ Unl	4 Pregnar	int at time of dea	ath -	er (Specify)		Ji lai icy	WOL	Day Year				
O. Bc at the dea	Physician/Me	Part II. Other significant conditi	9 Unknow		coulting in the un	darking cause o	in Part I	Tage Did!	tabassa usa soptribu	ute to the cause of death?				
S that is the general control of the	Ē	, , , , , , , , , , , , , , , , , , , ,	Total Commission (C.)	Jedin Dat Hot. 5	Schully in the co.	denying cause s	jiven in Faiti.	1 Ye		Probably 4 V Unknown				
ords, w require s been si should t	letec			-				24a Was	an 24b. We	ere autopsy findings available				
of Vital Records, in Physician: The law require the certificate has been simeral director, page 2 should be	Completed							auto perfo 1 ✔ Yes	ormed? dea					
tal Rec	Be Co	25. Was case referred to medical					of Death (Chec	ck only one)	Z NO I	Yes 2 No				
F Vita Physici r this c	2	examiner? 1 Yes 2 No	Hospital: 1 V Inp		ER/Outpatient					Other:				
on of ading P th : After e funera		27. Manner of Death 1 X Natural 5 Pend	28a. Date of (Month, D	Injury Day,Year)	28b. Time of Inju	· 1 —	ry at Work? res 2 No	28d. Describe	how injury occurred					
Division tal or Attendir rs after death at Director: A	ficat	2 Accident Inves	stigation 28e Place	of Injury - At ho	ome, farm, street,			28f. Location (Street and Number of	or Rural Route Number, City				
Div spital or ours aft seral Di filled in	Certification:		Id not be rmined (Specify)		,	Table 17, 2	ulla	or Town, \$	State)	I Narai Nodo Hambor, ony				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Ph	hysician: To the best of	of my knowledg	je, death occurre	d at the time, da	te and place, a	nd due to the cau:	se(s) and manner as	stated.				
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exar 29b. Signature and title of certifie	miner: On the basis of e	examination and ted.	d/or investigation			d at the time, date						
	-	2ab. Signature and the or contine				29c. License O. C.M			August 20, 20	(Month, Day, Year)				
and a	}	30. Name and address of person	who completed cause	of death (Item)	23a)				//uguot 20, 20	710				
Per	- [Donna M. Vincenti, M.			,	Penn Street,	Baltimore,	MD 21201						
∖ St Regist	ate rar	31. DAUG (30, 2010)	32. Regis	istrar's Signatur	axe									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kimberly Mowrer Month August 2010 10:30 am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Calvert **Examiner** 4b. City, Town, or Location of Death Burnett Calvert Prince Frederick Hospice 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-88-0875 Hours 1 □ M 2 🔀 F Days (Month, Day, Ye 03/03/ 49 Country) Director MD Usual Residence of Decedent or 28a-f shov should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Solomons 1 Kes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14250 Solomons Island Road 20688 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) Store Owner Shop/Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ann Conway Charles Fick ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO BOX 112, Solomons, MD 20688 James Mowrer / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cometery, crematory or other place)
Final Journey Crem. 9/1/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Maryland Cremation Services

Box 1413, Baltimore, MD 21203 Signature of Funecal Service License Dorota Marshall Marsha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ Breast disease or condition icar. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinju y that initiated events Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has the completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director. performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 잍 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 🕅 Other (Specify) HOSDice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number D005906

State Registrar

10

to 212

Prince Frederick MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year 2010 MACKEY JOAN 340 PM AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BON SECOUNS HUSPITAL B. FITIM ORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpia Country) MD 1 M 2 X F Days Hours Min 05-20-5 Months 218-64-1239 Director 53 Usual Residence of Decedent show or 28a-f show notified at 10b, County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Completed by Funeral 1923 Penrose Avenue 21223 USA 11 Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc African Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Divorced Specify: American Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th Grade Domestic various trades Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Pearline Townes Charles W. Mackey and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1923 Penrose Avenue Baltimore, Maryland Carlvne Davis-Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 09-02-10 Lansdowne, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Wylie Funeral Home P.A. 22. Name and Address of Facility N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ ALDS Medical resulting in death) Due to (or as a consequence of): Examiner HEPATINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed DRUG that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical EIZUNE P.O. Box 68760 DISUNDEN IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Tes __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ဂ 1 Yes Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After 1 🗷 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 SHEINFELD 22 SOUTH GREENE ST BACTIMODE GEORGNEY MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27442
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate	of Death .		Rec	g. No.	
Physic	ian/					2. Date of Death	1	3. Time of Death
ledical Exam	ine	Donna M. McLees				Month August 28,	Day Year 2010	0718 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of De	eath
		Civista Medical Center		LaPlata			Charles	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) If Under 1 Yea	ar If Under 24H	rs. 8. Date of Birth		Birthplace (State or
Director	1	041-44-5524 1 M 2XF	61	Yrs. Months Day	s Hours Mi	^{n.} 06–28–	1949 F°	reign Country) CT
	1	Usual Residence of Decedent						
any		10a. State 10b. County 1	0c. City, Town or L	ocation				10d. Inside City Limits
id how	_	CT New Haven	East Ha	ven				1 Yes 2XX No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number		10f. Zip Code		100	g. Citizen of What C	Country?
the Maryland a or 28a-f sho iffied at once.	Director	169 Rock Street		06512			USA	
rith th 23a 00ti		11. Marital Status 12. Was Decedent E	ver in U.S. 13	Was Decedent of His	nania Origina / S			and an Indian Black
ath v items	Funeral	1 Never Married 2 Married Armed Forces?		If Yes, specify Cubar			White, etc	nerican Indian, Black, c.
ter de		1 Yes 2 X 3 Widowed 4 X Divorced If Yes, Give Year] No	Yes 2 X No	enonifi.		Specify: Wh	ite
irs afi ural' mine	9	or Dates: 15. Decedent's Education (Specify only highest grade comp		edent's Usual Occupa		work done	16b. Kind of Busine	se/Industry
2 hou "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	durin	g most of working life			TOD. Raid of Busine.	ss/IIIuusii y
5-0036 led within 72 Hygiene. other than '	l d	12		rtment Hea	d		Governmen	nt
1 with	E O	17. Father's Name (First, Middle, Last)			18 Mother's Nam	e (First, Middle, Ma	aiden Surname)	
:15-(e filed al Hyg ced oth	Be	Donald Maloney			Claire		alderi odirlarile)	
21215-0036 Uld be filed within 72 hours after death with the Maryland Manal Hygiene Han "matural", or ritens 23a or 28a-f she event, the Medical Examiner must be notified at once	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Stree	et and Number or	Rural Route Numb	er City or Town St	ate Zin Code)
MD d 2 shot lith and n 27 is sumatic	-	Jennifer McLees / Daughter	15 (Central Av	e., Hamo	den, CT 0	6517	ate, zip dode)
ore, MEss 1 and 2 soft Health as If item 27		20a. Method of Disposition		sposition (Name of ce			20c. Location - City	or Town, State
		1 Burial 2XX Cremation 3 Removal from State		r other place)				
timent		4 Donation 5 Other Specify:		del Cremat		01/2010	Odenton,	
Baltimo permit Page Department of Important: injury or oth	Ш	21. Signat of Funeral Service Licensee	11	2. Name and Address		ro and Cr	omation S	Service, PA
		23a. Part I. Enter the disease, or complications that caused the	2	1023 Annap	olis Roa	d. Halet	horpe MD	21227
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not ent	er the mode of dying,	such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Alcohol a	nd Oxyco	done Intox	ication			Death
		or condition resulting in death) Due to (or as a consequence)	uence of):					
	<u>_</u>	Sequentially list conditions, b.						
	Examine	if any, leading to immediate Due to (or as a consequence). Enter Underlying Cause	ience of):					
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cuted nd ransi	<u> </u>	d						
760, ficate be executed g physician and the bunial - transit	ledical	x UNPENDED AMENDED 23a	,27,28a-f	per me g	908 10-1	5-10 vt		
760, Teate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome	of pregnancy		****		23d. Date of deliv	erv
587 rtific fing p		23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3 [Ectopic pregn	ancy	Month	Day Year
Box 68 death certifi the attending	Physician	4 Pregnant at tin	ne of death 5	Other (Specify)				
Ed fe	Į,							
Division of Vital Records, P.O. Box 68 all or Attending Physician: The law requires that the death certifiers death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	by F	Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying cause g	iven in Part I.			to the cause of death?
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e law e has ge 2 s	Ē					perform	ed? death?	?
R Th		25. Was case referred to medical		00.0	- (D 1) (O) - 1	1 ✔ Yes 2	No 1 ✓	Yes 2 No
ician ician s cert recto	B	examiner? Hospital: .	2 -		of Death (Check			
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ding After	ᇹ	1 Month, Day, Year	28b. Time		y at Work?	28d. Describe how	w injury occurred	
SiOI tten death ctor:	ăţi	2 Accident Investigation fd 8-28-1		nrs -	es 2 X No			alcohol and
ivis or A after Dire	≝	Suicide Could not be	/ - At home, farm, s	treet, factory, office b	uilding, etc.	28f. Location (Stre	eet and Number or F	Rural Route Number, City 1ewood Drive
Spital Oners filler	Certification:		sidence			Pomfret,	Md. 2067	5
e Hos 24 h e Fur etely		29a. Certifier (Check only 1 Certifying Physician: To the best of my ki						
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending routine the speed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	ation and/or investi	gation, in my opinion,	death occurred a	at the time, date an	d place, and due to	the cause(s)
	ž	29b. Signature and title of certifier		29c. License		ľ	9d. Date signed (N	fonth, Day, Year)
		Il I Du Konto	_ >	O.C.N	A.E. DON	E /	August 29, 201	0
-		3. Name and address of person who completed the of deal	h (Item 23a))				
	-	Theodore M. King, Jr., MD. Assistant Med	,	111 Penn Str	eet, Baltimor	e, MD 21201		!
St	tate	31. Date filed (Month, Day, Year) 32 Registrar's	Signature 🛕					
	trar	SEP 0 1 2010 Jenus	A hor	artho				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atti Ann Mullic	kin	1- For State Registrar	St	ate of Maryl		partment o e <i>rtificate o</i> a		and Men	ital Hy	_	Reg. No. 2 ()	0 2744
Physic Medical Exam		1. Decedent's Nam								Date of De	ath Day Ye	ar	3. Time of Death
neulcai Exam	me			n, give street and n	umber)		4b. City, Town	, or Location o		August 2	9, 2010 4c. County	of Deat	0455 hrs
		407 Alabam	na Avenue				Salisbury	,			Wicomi		
Funeral Director		5. Social Security N		6. Sex		. last birthday)	If Under 1 Months	_	_		irth (MM/DD/YYY)	9. Bir Foreig	
Director		Usual Residence o		1 M 2 X F	39	Yrs		7,04,0		08–24	1–1971		ountry) MD
any		10a. State	10b. County		10c. Cit	ty, Town or Locat	ion						10d. Inside City Limits
Maryland 28a-f show any d at once.	ō	MD	Howar	rd .	Co	lumbia							1 Yes 2 XN
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygenes and matter it filem 27 is marked other than "natural", or items 23a or 28a-f shown of other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Nu		ıv #2			10f. Zip Cod 21044		.		10g. Citizen of WI USA	nat Cou	ntry?
with the		11. Marital Status			cedent Ever in I	Ū.S. 13. Wa	s Decedent of		nin? (Spec	cify Yes or N		- Amer	ican Indian, Black,
death	Funeral	1XX Never Marrie	ed 2 M	arried Armed F	orces?		es, specify Cul					e, etc.	
s after rral",	à	3 Widowed		orced If Yes, Give Yes or Dates: cify only highest gra			Yes 2XX				Specify:		nite
72 hour	eted	Elementary/Seco		College (16a, Deceden during m	ost of working				16b. Kind of Bu	siness/i	Industry
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be Co	James S	·	,					· ·		Maiden Surname Scruggs)	
212 ould be Ments mark ic even	To B	19a. Informant's Na				19b. Mailing	Address (St	1			mber, City or Tow	n, State	, Zip Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within peparment of Heath and Mental Hygiene. Important: If item 27 is marked other It injury or other traumatic event, the Med				kin / Fat		_					, FL 333		
Baltimore, permit. Pages I as Department of Hee Important: If ite		20a. Method of Disp 1 Burial 2X		3 Removal fr	om State	Place of Dispos crematory or oth	ner place)			Date 1 / 2010	20c. Location -	-	
Itim it. Pag urtment ortant: ry or o		4 Donation 5 21. Signature of Fu			W.	. Arunde	I Crema			1/2010	Odentor	1, M	Б
Department of the property of		Mal	601	20	M0145	a IBa	ilev Fu	meral	Home	and C	remation	ı Se	rvice, PA
Physician /Medical		23a. Part I. Enter the failure. List onl	e disease, or y one cause	complications that c on each line.	aused the deat	h. Do not enter th	e mode of dyir	ng, such as ca	ardiac or re	espiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and
Examiner		Immediate Cause (I			otic In	toxicati	ion						Death
		Sequentially list cor	nditions,	b.	consequence								
	ine	if any, leading to im cause. Enter Under	rlying Cause	Due to (or as a	consequence	of):							
ed isit	Examiner	(Disease or injury the events resulting in o		Due to (or as a	consequence	of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	ledical l	X UNPENDED		dAMENDED	23a - 27	,28a-f p	er me	o907 9	-13-1	0 vt			
68760, certificate be ex nding physician se as the burial	Med	IF FEMALE:		23c. If yes,	outcome of preg		-	6,01			23d. Date of	delivery	<u> </u>
OX 6876 eath certificate attending phy for use as the 1	sician/N	23b. Was decedent past 12 months		I I I II II II II II II II II II II II	irth ant at time of d	=	al death	3 Ectopic	pregnancy	/	Month	-	oay Year
Box e death co	Physic	1 Yes 2 N	o 9 🗸 Unk			eau 5 Oth	er (Specify)						
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ds, F equires een sign										24a. Was			topsy findings available
Division of Vital Records, and or Attending Physician: The law requirers after death. After this certificate has been similed in by the funeral director, page 2 should the	Completed									autop perfo	sy p rmed? d		ompletion of cause of
tal Recian: The certificate ector, page		25. Was case referre	ed to medical	1		_ 	26. Pla	ce of Death (Check only	1 Yes	2 No 1	✓ Ye	s 2 No
on of Vital Figures in the fine or After this certificate the fineral director,	To Be	examiner? 1 ✓ Yes 2		Hospital: 1 I	npatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing H	lome 5	Residence 6	Other	: Scene
n of ding P h. After	on:	27. Manner of Death 1 Natural	5 Pendi		of Injury , Day,Year)	28b. Time of In	· _	jury at Work?		d. Describe I	now injury occurre	d	
risio r Atter er deat rector	ficati	2 Accident 3 Suicide	Inves	tigation 10 8-	-29-10 e of Injury - At h	fd 4:48	am		_ lu	Inknow	Street and Numbe	r or Rui	ral Route Number, City
ospital or hours aft uneral Di y filled in	Certification:	4 Homicide		not be		e dwelli		3,		or Town, S	tate) 407 A	Laba	ama Ave.
Divi		29a. Certifier (Check only one)	Certifying Ph	ysician: To the bes	t of my knowled	lge, death occurr	ed at the time,	date and plac	ce, and du	e to the caus	e(s) and manner	as state	d
To th withi To th	Medical	29b. Signature and t		and manner st	ated.			nse number	urred at th	e time, date	and place, and du		
		() ad	who -					.M.E.			August 29,		, Day, 16al)
		30. Name and addre		who completed caus	e of death (Item	n 23a)					<u> </u>		
	لي	Laron Locke		sistant Medica	Examiner	111 Penn	Street, Balt	imore, MD	21201				
St Regist	~~~	31. Date filed (Month		O Server	gistrar's Signati	ure parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Muriel Yvonne ugust : 40 PM Moore 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A BALTIMORE CITY HOSPITAL OF 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 📑 Hours 0472341939 Maryland Director 212-40-2192 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Pikesville MD Baltimore Co. 10e Street and Number 10g. Citizen of What Country? Funeral Sudbrook Lane 21208 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12th Grade Assembler Western Electric Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marken any injury or any Thurston A. Brooks Eunice Satterfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Brooks(son) 6639 Dalton Dr., Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Permatory or other place H 1 \square Burial 2X Cremation 3 \square Removal from State 09/07/10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee អ្នកទទ្ធម្នាក់ថ្មាន ទទួល Jr. Funeral Home PA 2140 N Fulton Ave.,Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Pneumonia Aspiration disease or condition resulting in death) Medical Examiner months Tema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hibrillation 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown chronic eyetitis 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 performed? Yes 2 No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo မှ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number CA RES-000 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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For State Registrar 1. Decedent's Name (First, Middle, Last) Esther Megginson 2. Date of Death 3. Time of Death Physician/ onth 150 Medical 4a. Facility Name (if not institution, give street **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospico -Northwest Hospital Kandallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) OS CS 1944 218.44. 1 🗆 M 2 🗙 F Months Min Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Road 21207 Digby USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Grove life. DO NOT use retired) Sorina Elementary/Seconday (0-12) College (1-4 or 5+) Hospital State 12Hz grade NIA Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ King ornelius Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband Road Baltimore Megginsor MD 21207 Werson. Diaby 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Woodlaun 8 2010 Woodlawn, MD 311 emeten Signature of Funeral Service Licenses 22. Name and Address of Facility Vaugno C. Theene Filiperal Services Road Randaystown Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear) failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a o sequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. attending physician and for use as the burial-transif Cause (Disease or I that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death Dav Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital 2 No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27 Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 \square Pending injury work? Accident Suicide 2 🗆 No Investigation M Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) 10 B MP 31. Date filed (Month, Day, **SEP 0 1** State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland					Mental Hy	giene	001	0 07116
			Registrar	-4)		Cer	titicate	of Deati	h	_	Reg. No.	201	0 2/446
	Physicia Medic		1. Decedent's Name (First, Middle, La:	ELENDEZ						2. Date of De Month AUGUS	Day	Year 20/0	3. Time of Death 08:47 AM
	Examin		4a. Facility Name (if not institution, give JOHNS HOPKINS BAYV		L CE	NTFR	4b. City, T	own, or Location	on of Death		<u> </u>	County of Dea	ath
	Funeral		5. Social Security Number 6. S	ex 7. Age		st birthday)	If Under		der 24 Hrs.	8. Date of Bir	th	9. B	irthplace (State or Foreign
F	Director		122-56-3274 1 Usual Residence of Decedent	□ M 2 X F	48	Yrs.	Months	Days Hour	s Min.	July 1	0,196	C	ountry) Onx. New York
	nd how	7	10a. State 10b. County		10c. City.	Town or Loc	cation						10d. Inside City Limits
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Director	Maryland Baltim	ore		Dund	alk						1 🗆 Yes 2 🛣 No
	a or 2	Ö	10e. Street and Number		-		10f. Zip				10g. Citi	zen of What C	ountry?
	th with ms 23 must	Funeral	16 Court Pleasant	Apt A8				21222			US	5A	
(O	er dea or iter niner	y Fu	11. Marital Status 1 Never Married Married	12. Was Decedent E Armed Forces?		13. V	Vas Decede Yes, specif	nt of Hispanic y Cuban, Mexi	Origin? (Sp can, Puerto	pecify Yes or No- p Rican, etc.)		 Race - Am Black, Whi 	
ě Ö	urs afte ural", Il Exar	Be Completed by	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.		1	☐ Yes 2	No Spec	cify:			Specify: Pu	erto Rican
<u>5</u>	72 hou "nat ledica	ple	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give k	and of work	Occupation done during m	nost of wor	king	16b. Kir	nd of Business	Industry
72	within jiene. er thar the N	S	Elementary/Seconday (0-12) 12 years	College (1-4 or 5	+)		onoruser fice (Mi ⁻	litary	
힏	filed vial Hyg		17. Father's Name (First, Middle, Last)						other's Nan	ne (First, Middle,			
Maryland 21215-0036	should be file n and Mental 7 is marked o raumatic eve	2	Hector Oyola							Reyes			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T) Juan Melendez	ype, Print) Husband						ral Route Numbe A8, Dune			
Je,	of Health of Health fitem 27 rother tr		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name	of		Date Cember	<u>'</u>	cation - City o	
Baltimore,	Page 1 ment of tant: If it jury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State (y)		metery, crem Lawn				ember 2010	Dunc	dalk,Ma	ryland
Bai	permit. Page Department Important: I any injury or once.		21. In Jure of Faral Service Licens	Conn	ell	es 3	Name and	Address of Fac Ly Fune	ral H	lome Of I	Dunda	alk,P.A	· 21222
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only o	plications that caused ne cause on each line	the death.	Do not ente	r the mode	of dying, such	as cardiac	or respiratory arr	est,	I I No Mus	Approximate Interval Between
- 1	Physician/		Immediate Cause (Final disease or condition			ORY F.	AILURI	F					Onset and Death 2 WETKS
	Medical Examiner		resulting in death)	Due to (or as a	•		A07 1	FAILURE					3 15406
		iner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying	Due to (or as a	Conseque	nee oij.							3 YEARS
	cuted	Examiner	Cause (Disease or linjury that initiated events			S ME	LLITH	<u> </u>				_	10 YEARS.
2	death certificate be executed re attending physician and ed for use as the burial-transit	dical E	resulting in death) Last	Due to (or as a	conseque	nce or);							
09/	icate j phys is the	ledi		a									
/89 X	ending r use a	an/N	zob. Was decedent pregnant	23c. If yes, outcome o	of pregnance	cy death 3 🗆	Ectopic pr	anancy			2	3d. Date of de	elivery
. Box	he death y the att ched for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of de	ath 5	Other (spec	cify)				Month	Day Year
7. O	s that t gned b	by P	Part II. Other significant conditions co	ontributing to death bu	it not result	ting in the un	derlying ca	use given in Pa	art I.	23e. Did to	bacco us	e contribute to	the cause of death?
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000	hasb hasb je 2 st	Completed								24a, Was a autop	sy	24b. Were au prior to death?	topsy findings available completion of cause of
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/Ita	sicia s cert	To Be	evaminer?	Hospital: 1 🗹 Inpatie	-+ 0 D F	D/O-++:		26. Place of De					
0	ng Phy ter this neral c		27. Manner of Death 1 🖸 Natural 5 🗆 Pending	28a. Date of injury (Month, Day,	/ 2	8b. Time of injury		Injury at work?	Nursing Ho	ome 5 Resid			ify)
0	ttendii death. tor: Ai the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				М	1 🗆 Yes 2	□No				
Division of Vital Records,	salor A safter al Direc		4 Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	e, farm, stree	et, factory, o	office		28f. Location (Si City or Town		Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examinonly one) 3 Certifying Nurs	ician: To the best of ner: On the basis of exe e Practioner: To the b	amination a	nd/or investig	ration, in my	opinion death	occurred a	t the time date ar	d place a	and due to the	cause(s) and manner stated
	Vithin To the comp		29b. Signature and title of certifier	- 1	e. iiiy k			icense number	,	2		signed (Monti	
				M				RES	-000)	AUGU	ST 29,	20/0
		Ì	30. Name and address of person who con STEVEN HSU, MD	4940 FA	ASTER	N AVE	NUE	BALTI	MORE	, MD =	2122	4	
	State Registra		SEP 01 2010	32. Registrar	's ignatur	fact	1					•	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Frederick A. Ottenbacher Sr. entempe-Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Med. Cen Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 XM 2 □ F 10/02 Director 96 <u> 164-</u>10-6217 NJ Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Anne Arundel Pasadena 1 Yes 2XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Ross Drive 627 U.S.A. 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3
Widowed 4 Divorced If Yes, Give Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Parlin Photo. Ser. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Frederick A. Ottenbacher Josephine Trehearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredrick A. Ottenbacher Jr 627 Ross Drive, <u>Pasadena</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ¹X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cem. 9/3/10 Toms River, NJ 4 Donation 5 Other (Specify) Sign ne of Full ral Service License 22. Name and Address of Facility 412 Main Street Carmona-Bolen F.H. Toms River, N.J. 08753 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) nmohi day Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Litter Ordenying Cause (Disease or linjury Due to (or as a consequ Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of has performed' death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 1 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? Natural
Acciden
Suici Director: After injury 5 Pending Accident
Suicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number M201D person who completed cause of death (Item 23a) (Type, Print) led (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

FENBACHES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27448 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth 2010 : 15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howa If Unde 7. Age (In vrs. last bitthday) 8. Date of Birth (Month, Day, July 10 Birthplace (State or Foreign Country)
 MD **Funeral** 1 - M 2 - F Months Hours Min. 91 Director 213-10-5898 1919 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Sykesville Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5409 Fantail Dr. 21784 United States death v 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2XX No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: White Completed 3x Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) Manager Sales Dept. Stewart and Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ethel Belle Webster Charles Kammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Fantail Dr. Sykesville, MD 21784 William Palmer (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/4/2010 Sykesville, MD Lake View Mem Park 21. Signature of Funeral Service Li any in once. 22. Name and Address of Facility Burrier-Queen Funeral Home W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 disease or condition Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Fibrillation Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 X No Other: ER/Outpatient 3 DOA 1 Inpatient 2 I 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 216

Registrar

State

DHMH 17 Rev 7/2009

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dombia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:55 P.M. JoAnn Rose 2010 Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs,
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 1,1947 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Director 212-50-0555 July Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Balto. Parkville Md. must be n ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8643 Hoerner Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced er than "natur, the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology 10th Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ William Bardroff Mary Staylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Teal 304 Bright Oaks Drive BelAir, Md. 21015 Department of Healt Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview 8-31-2010 Balto.Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Buen D. Jeans 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ PTIC disease or condition resulting in death) Medical Examiner PNEYMONI Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART PAILURE, HYPERTENSION, CIRRHOSIS Completed 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE BULMONARY DUEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2^MNo Other: ဂ္ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Watural 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Name of the cause (s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RESOUD August 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 1 och Raven (ANTO(H)) HITAL MD. GOOD SAMONTON HOSPITAL. CANTOCH JUHITAL 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2010 Hunter D. Riley 12:50p ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9301 Bethel Road Frederick Frederick If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min Vi<u>rginia</u> **Director** 220-54-3435 61 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9301 Bethel Road 21702 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, med Forces Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 X Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Steel Worker Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Riley John Ella Mae Kennev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Riley / Son 2406 Prentice Court, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 09/01/2010 Hanover, Maryland 21. Signature of Funeral Service cen e 22. Name and Address of Facility Anatomy Gitts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final O set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and defached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes Completed 2 No 3 Probably 4 Unknown s peen si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 12 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No after death Director: / Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Frantismors T. the boat of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Frantismors T. the boat of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael 702 31. Date filed (Month, Day, Year, Registrar

10-06456	
Brenda Lee Ro	op

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 2745 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertificate of		ia wichtai ii		g. No.	
Physic Medical Exam		Decedent's Name (First, Middle,La Brenda Le	,				Date of Death Month	Day Year	3. Time of Death
medical Exam		4a. Facility Name (if not institution, gi			lb. City Town o	r Location of Death	August 26,	2010 4c. County of Deat	1212 hrs
		Carroll Hospital Center			Westminst			Carroll	
Funeral Director		5. Social Security Number 6. S 217-76-6016	17	. last birthday)	If Under 1 Year	ar If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	
Director		1	м 2 г 47	Yrs.		ys Hours Wiln,	Nov 21 1	1962 C	puntry) D. C.
any		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location	on				10d. Inside City Limits
and show	<u>ا</u>	Md Carrol	.1 W	oodbine					1 Yes 2 No
Maryl r 28a-f	Director	10e. Street and Number 1838 Gum Road	·		10f. Zip Code	0.7	100	. Citizen of What Cou	ntry?
with the Maryland ms 23a or 28a-f show be notified at once.		11. Marital Status	Leo ve		2179			US	
eath w	Funeral	1 Never Married 2 X Married	12. Was Decedent Ever in I		Decedent of Hiss, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
after d	by F		1 Yes 2 X No	1	Yes 2 ^{XX} No	specify:		Specify: Wh	ite
hours 'natur		15. Decedent's Education (Specify o		16a. Decedent	's Usual Occupa st of working life	tion (Give kind of w	rork done 1	6b. Kind of Business/	Industry
336 thin 72 te. than '	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		maker			Her Hor	n e
5-0036 iled within 7/ Hygiene. I other than		17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, Ma	_	
121 d be fi fental }	Be	Freeman Duga						tterwhite	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in the Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified as once.	오	19a. Informant's Name/Relationship (T	husband	19b. Mailing	Address (Stree Gum Roac	etand Number or R 1, Woodbi	ural Route Numbe	er, City or Town, State	, Zip Code)
Te, No. 1 and 1 Health		20a. Method of Disposition	20b.	Place of Disposit	ion (Name of cer			20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea important: If ite		1 Burial 2 Cremation 3 4 Donation 5 Other Specify.	Ma	crematory or other		Aug	30 2010	Woodbine,	MD
Salti ermit. Separtn mport		21. Signature of Funeral Service Licen		22. Na	me and Address	of Facility Bur	rier-Oue	en Funeral	Home
Physician	_	23a. art I. Infer the disease, or comp	lications that caused the death	121	2 West (11d Tiber	tw Pond	Winfield	Md 21784
/Medical		failure List only one cause on ea	Seizure disor		a. a. a. a. a. a. a. a. a. a. a.	oddi'i do odi'dido o;	respiratory arrest	, shock, or near	Approximate Interval Between Onset and Death
Examiner		and the second s	Due to (or as a consequence of						
	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):					
	Examiner	cause. Enter Underlying Cause [Disease or injury that initiated c.	Due to (or as a consequence o						
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icate be executed g physician and the burial - transit	Medical	X UNPENDED	AMENDED PII per 23a,27,per M	M EG910 E g908 1	1 2/6/1 0/4/10	0 TT TT		· · · · · · · · · · · · · · · · · · ·	
68760, certificate be nding physicia se as the buris		IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy				23d. Date of delivery	
30x 68 death certifi ne attending I for use as	icia	past 12 months?	4 Pregnant at time of de	ath =	Ideath 3 [ir (Specify)	Ectopic pregnan	cy	Month D	ay Year
h. Box the death or y the attenday by the attendant check for use	Physician	1 Yes 2 No 9 V Unknown Part II. Other significant conditions	3 Olikilowii	opultion in the					
P.C es that igned to deta		Atherosclerotic				iven in Part I.		cco use contribute to t	
rds, requir	Completed by		-				24a. Was an	24b. Were aut	opsy findings available
teco The law ate has	g II						autopsy performe 1 ✓ Yes 2	d? death?	empletion of cause of
tal R	a B	25. Was case referred to medical examiner?			26.Place	of Death (Check or		No 1 ✓ Yes	2 No
f Vit Physic er this	유	1 Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2	ER/Outpatient				sidence 6 Other:	
on control on the street of th	ü	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju		y at Work? 2 es 2 No	8d. Describe how	injury occurred	
Visic or Atto fler des Directo	licat	2 Accident Investigatio 3 Suicide 6 Could not b	28e Place of Injury At he	ome, farm, street,			8f. Location (Stree	et and Number or Rura	al Route Number City
Di spital nours a filled	Certification:	4 Homicide determined					or Town, State		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ल्र	29a. Certifier 1 Certifying Physicia (Check only 2)	n: To the best of my knowled On the basis of examination a	ge, death occurred	d at the time, dat	e and place, and de	ue to the cause(s)	and manner as stated	1.
To T com	Med	29b. Signature and title of certifier	and manner stated.		29c. License			od. Date signed (Mont	
		0 01	111		O.C.N			ugust 27, 2010	., Jay, 19d1)
4	-	0. Name and address of person who co			1				
(hief Medical Examiner		Street, Balti	more, MD 212	01		
Sta Registi		11. Date filed (Month, Day, Year) SEP 0 1 2010	32. Registrar's Signatu	re					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g907 9-13-10 vt State of Maryland / Department of Health and Mental Hygiene 20 10 27452 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bernice T. Rudolf 6:00 A. M August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death North Arundel Health & Rehab Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours (Month, Day, Year) 03/11/1917 93 Director 181 07 4200 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore 1 Yes 2 X No Marvland 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 520 E. Church Street 21225 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (not available) (not available) 19a. Informant's Name/Relationship (Type, Print)
Karen Hobbs / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Russett Leaf Terrace Woodsboro, Maryland 21798 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 08/31/2010 Holy Cross Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metry All disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title 29d. Date signed (Mgnth, Day, Year) 30 10 who completed cause of death (Item 23a) (Type, Print) Oly Burne MD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For 1 - State Registrar	State of Maryl		ertment of ertificate of		and Menta		Z 11 1	0	27453
	Physicia	ın/	Decedent's Name (First, Middle, Last	Wendell H					Reg. te of Death onth gust		010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give Heartland Healt	street and number)	nter	4b. City, Town	or Location of			4c. County of	Death	3:40a M
	Funeral	f	Social Security Number 6. Security Number	ex 7. Age (In y	rs. last birthday)	If Under 1 Ye	ar If Under 2	24 Hrs. 8, Dat	e of Birth	1 9	. Birthpl	Seorges
3-	Director ≥		Usual Residence of Decedent	M 2 □ F 86	Yrs.	Months Day	/s Hours	0.7	717/1	924	Countr	D.C.
	faryland Ba-f show tified at	ector	10a. State MD 10b. County Mont	gomery 10c.	. City, Town or L	ocation T	akoma	Park			10	d. Inside City Limits 1 Yes 2 No
	with the N 23a or 20 ist be no	Funeral Director	10e. Street and Number 7620 Maple	Avenue, #	208	10f. Zip Cod	20912	2	10g.	Citizen of Wha	ut Count	-
980	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 U.S. 13.	Was Decedent of If Yes, specify Co	uban, Mexican,	in? (Specify Yes Puerto Rican, e	or No- etc.)	14. Race - Black, ' Specify:	America White, et	c.
Maryland 21215-0036	thin 72 hou sne. than "natu he Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12) 1 2		(Give	edent's Usual Occ kind of work dor DO NOT use retire	e during most o		16b	. Kind of Busin		ality
and 2	12 should to filed within 7 aith and Mental Hygione. 27 is mar ed other than ir traumati event, the M	To Be (17. Father's Name (First, Middle, Last)			unkn.		r's Name (First,	Middle, Maide			
laryla	should and Mer is mar aumati		19a. Informant's Name/Relationship (T)		19b. Mail	ing Address (Stre	et and Number	or Rural Route	Number, City	or Town, State	unk e, Zip Co	
re, N	E E E		Delores Stringe 20a. Method of Disposition	20	b. Place of Disp	osition (Name of	!	Date		akoma Location - Cir		
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		1 ☐ Burlal 2 🔁 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	,,		matory or other pourney Co	<u> </u>	/2/2010	,	Woodbiı	ne,	MD
Ba	perm Depa Impo any i		21. Signature of Funeral Service Livens	* Porota Mars	snall 2	2. Name and Add Mar PO	yland Box 14	Crema 13, B	tion altimo	Serviore, N	ies ID 2	1203
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the d	1	ter the mode of d	ying, such as ca	ardiac or respira	atory arrest,			Approximate nterval Between Onset and Death
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Mg	cate be executed physician and sthe burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):							
8760	tificate b ng physi as the b	Medical	IF FEMALE:	d			-			T		
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of prey 1 Live Birth 2 Fe 4 Pregnant at time 9 Unknown	Fetal death 3 [☐ Ectopic pregna☐ Other (specify)				23d. Date o Month		y Day Year
, P.O	es that thisigned by be detail	ρ	Part II. Other significant conditions co	ontributing to death but not	resulting in the	underlying cause	given in Part I.	230				cause of death?
ords	iw requir is been s 2 should	Completed	,					24	a. Was an autopsy	24b, Wer	e autops	y findings available pletion of cause of
l Rec	n: The la ficate ha or, page		25. Was case referred to medical			00	Diagonal Danie		performed?	dea		_
Vita	is certi	To Be	avaminar?	Hospital:	☐ ER/Outpatie	_ [0	thor	(Check only on sing Home 5	,	6 ☐ Other (S	Specify)	
n of	ding Ph th. After th funeral	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time o injury	w		28d. Des	scribe how inj		,	
Division of Vital Records, P.O.	al or Atter s after dea nl Director ed in by the	l Certificate:	3 Suicide 6 Could not be determined		t home, farm, str cify)			28f. Loc	ation (Street a or Town, Sta	and Number o. te)	r Rural R	oute Number,
_	e Hospit 124 hour e Funera leted filk	Medical	(Check 2 L Medical Examin	ician: To the best of my knowner: On the basis of examina e Practioner: To the best of	ation and/or inves	tigation, in my opi	inion, death occu	urred at the time	date and pla	ce, and due to	the cause	e(s) and manner stated
	To the within To the Comp		29b. Signature and title of certifier		. my raiowooge,	29c. Lice	nse number		294 [ate signed (M	onth Da	v Voorl
	3		30. Name and address of person who c	ompleted cause of death (It	tem 23a) (Type,	Print)	AHMI	lou ins	14 4	ym?	9	
- 32	Stat Registra	e	31. Date filed SEP 0 1°2010	32. Registrar's Sig		Ke	5, . 		90	ذ -		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Eva Elizabeth 2. Date of Death Schaefer Physician/ August 31 Day 2010 ear 10:00 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death West 37th Street Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 212-07-4721 1 □ M 2🛣 F Months 89 0272074921 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural". 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 □ No 10f. Zip Code 21 211 10e. Street and Number 810 West 37th Street 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: If Yes, Give Year or Dates White 3 ₩ Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Quality Controller Manufacuring Be ^{17. Father's Name (First Middle, Last)} Elmer Marshall D. Ambrose 18. Mother lane (Final Middle, Shiel Legne) 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Smith/Daughter 810 West 37th Street, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Final Journey Crem. 9/3/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition conten Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 Wo Month Pregnant at time of death Day After this certificate has been signed by the structure director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 2 🕅 No Hospital Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident Investigation 2 🗌 No To the Funeral Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (/

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res

Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27455 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WILLIAM SCHWINN 5-30 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS-CATONSVILLE COMMONS CATONSVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 🗆 F Hours Min. Country) UNKNOWN JUNE**, 23, 1939 Director 219-78-6585 71 Yrs Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f BALTIMORE MD CATONSVILLE 1 🗌 Yes 2 🗓 No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 23a 16 FUSTING AVE 21228 USA items 2 be filed within 72 hours after death vertal Hygiene. ked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) UNKNOWN BUSBOY RESTAURANT Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname, ဂ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 FUSTING AVE CATONSVILLE, MD 21228 EDYTHE KEYS-GUARDIAN Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 9/1/10 GLEN BURNIE, MD 4 Donation 5 Other (Specify) 21. Sign 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD e disease, or ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List or Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached the Unk*n*own 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page 2 performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death s after death.

I Director: After the din by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature as 36

Registrar

DHMH 17 Rev 7/2009

Leelen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

1009

32. Registrar's Signature

URAKINIA

2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 27°2010 ANNA CAROLYN SERVARY 5:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Young) Funeral . Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 □ M 2 🛣 F Months Year MARYLAND Director 218-22-2942 85 JUNE Usual Residence of Deceden 28a-f show 10a. State with the Maryland 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD BALTIMORE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6132 ALLWOOD COURT APT 231 21210 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc ō ğ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify. "natural", If Yes, Give Completed 3 Widowed 4 X Divorced Specify: WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than filed within 7, al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the BALTIMORE CITY SCHOOLS t. Page 1 and 2 should be filed withi triment of Health and Mental Hygiens rtant: If item 27 is marked other th jury or other traumatic event, the ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ GEORGE F. CROWTHER MARGARET REDIFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMALEE McCOMAS- DAUGHTER 16708 JM PEARCE ROAD MONKTON, MD 21111 20a, Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of P
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State DRUID RIDGE CEMETERY 8/30/2010 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME INC. 6415 BELAIR ROAD BALTIMORE, MD 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician, meeta stutic colon cancer rars Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): pyperitar Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?
1 Yes 2 No Month Day Year signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 X **Director:** After this certificate a in by the funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after hin 24 hours at the Funeral D npleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 0070635 8127110

State Registrar

DHMH 17 Rev 7/2009

5+ -

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N charles

32. Registrar's Signature

6701

31. Date filed (Month, Day, Year)

SEP 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:52 PM Andres SanJuan 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SAINT JUSEPH MEDICAN CENTER TOWSON 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min November 30,1939 cratilippines 70 558-62-4267 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Kingsville Balto. Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21087 USA 7016 Sunshine Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give 1 ☐ Yes 2 1 No Specify: Asian Specify: Completed 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Conductor Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anastacio Briones Marcosa Galvez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Md. 21220 5 Nickel Court Cinia Pussler
Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 19-4-2010 Fallston, Md. Highview Memorial 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition Due to (or s a consequence of): MINUTES Medical resulting in death) Examiner YEARS AD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the otherwise and the contract of the funeral Director: attending physician and I for use as the burial-transit HYPERCHOLESTEROLEMIA AM that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 🗆 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier August 28,2010

Registrar DHMH 17 Rev 7/2009 ERIC

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEALVOIS

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21204

10-06536

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Louis Scott 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 30, 2010 0329 hrs Medical Examiner Louis Scot

4a. Facility Name (if not institution, give street and number) Scott 4c. County of Death 4b. City, Town, or Location of Death Baltimore NA University Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** 98-9556 Days Min Months Hours Country) MD Director 29 11-05-80 215-98-9056 1 X M Yrs 2 F Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iny Baltimore NΑ 1 X Yes 2 No hours after death with the Maryland Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21217 2738 Parkwood Avenue Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? Yes Specify: American If Yes, Give Year Divorced Yes 2 X No specify: 3 Widowed ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 Forns of Health and Mental Hygiene.
ant: If item 27 is marked other than ""
or other traumatic event, the Medical E Local #486 ltimore, MD 21215-0036 Plummer Apprentice 12th Grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) R. Riddick Dorothy Scott, Sr. Louis Α. Be 19a. Informant's Name/Relationship (Type, Print) Notrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2738 Parkwood Avenue Baltimore, MD 21217 Dorothy Riddick Scriber 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition King Mem. Pk. 1 X Burial 2 Cremation 3 Removal from State Randallstown, MD 09-04-10 Donation 5 Other Specify 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral Service Lic Insec 638 N. Gilmor Street Baltimore, MD 21217 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or compl **Physician** Between Onset and Modica Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and tran Physician/Medical AMENDED #5perFH, G907, 9/15/2010, WS UNPENDED attending physician or use as the burial Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 P ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 V Yes 2 No 28a. Date of Injury 27. Manner of Death 28c. Injury at Work 28d. Describe how injury occurred Certification Aug 30, 2010 Subject shot 0249 hrs Natural 5 Pending 1 Yes 2 V No Director: I in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2700 Block of Parkwood Avenue, Baltimore, MD determined (Specify) Local Street e Funeral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME August 30, 2010 O.C.M.E. who completed cause of death (ftem 23a) Theodore M. King, Jr., MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 31. Date filed (Mopth Pax Yar) 2010

Registrar's Signaty

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Depedent's Name (First, Middle, Last) 2. Date of Death 4:50 AM Physician/ (ODNE) SMEDLE AVGUST 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN HOSPITE BALTIMORE 100 D If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year MAY 25, 1 1 **X** M 2 □ F Months Hours Director 216-28-5720 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 28a-f 1 X Yes 2 No MD BALTIMORE ROSEDALE 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be a Funeral 1 ROBIN WAY CT. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 ♣ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION 12TH LABORER and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည JAMES SMEDLEY VTRGTNTA SMEDLEY and 2 should b Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. WENDY DePETRIS/DAUGHTER ROBIN WAY CT. . ROSEDALE. MD 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/27/2010 HANOVER, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licens eser 2007-09 FASTERN AVE BALTIMORE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final NEVMONIA Pnysician Medical resulting in death) Due to (or as a consequence of): Examiner 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the a ☐ Pregnant : P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After t work? injury 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After a property of the function of the fun 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Mours MD 0058913

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHL

. Registrar's Signature

MANISHA

5601 BALT

601 LOCH RAVEN BOULEVARD ALTIMORE, MARY LAND 21239

ID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Month Day 26 Physician/ 11:5ZAM Virgie Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bry view Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 4-18-1918 Hours 1 □ M 2X XF 216-24-2757 92 N.C. Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1√2 Yes 2 □ No Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 5 10e Street and Number must be Funeral **23**a 233 N. Silver Court 21231 S Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 24 No Black, White, etc. ō by 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after Specify: Black 1 ☐ Yes 2 XNo Specify: If Yes Give 3 X Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Macatang injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 6th grade Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Minnie Winston Joseph Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Meriam Ct Owings Mills, MD 21117 Nora Moore-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Arbutus Memorial 9-1-2010 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ATTEST Physician/ ardiac 24 hou disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Condiac sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant 5 Other (specify) Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure, Hypertension 1 Yes 2 No 3 Probably 4 Unknown has been sign e 2 should t Florillation, Hyperlipidenia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? page 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 🗌 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) RES-000 August 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1200 S. Conkling Sc. Apr. 350 Baltruck, HD 21224 32. Registrar' Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #19a Per FH C907 9/10/10 JH
State of Maryland/Department of Health and Mental Hygiene 27462

Certificate of Death
Name (First, Middle, Last)

2. Date of Death
Month Day Year
3. Time of Death

		_1	State Registrar					Cer	tificate of	Death			Reg. No).			
		,	1. Decedent's Na	me (First, Middle	, Last)							2. Date of Dea	ath Da	ıv	Year	3. Time of	
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	Examin		4a. Facility Name	(if not institution	, give st	treet and number)			4b. City, Town,	or Location	n of Death	J	4c	. County o	of Death	N/A	
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	ath w	Funeral	13 POM	ONA SOU'		API . Z 12. Was Decedent Ev	er in U.S.	13. \	Nas Decedent of	Hispanic C	Origin? (Spe	ecify Yes or No-			- Americ	an Indian,	
0	or ite	by F		arried 2 🗌 Mar	ried	Armed Forces? 1 ☐ Yes 2 💢 N	lo		f Yes, specify Cul			Rican, etc.)			k, White, e		
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7	e filed within 72 hours after death with the Maryland thygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Se	econday (0-12)		College (1-4 or 5+)		O NOT use retire MEMAKER	4)				OWN I	HOME		
	uld be filed witl I Mental Hygiei narked other i natic event, th	Be	17. Father's Name	e (First, Middle,	Last)				111111111111111111111111111111111111111	18. Mo	ther's Nam	e (First, Middle,	Maiden	Surname)		
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Maryland	of Health and Denti of Health and Ment fitem 27 is marked rother traumatic				plo the	pe, Print) S man/son	19	9b. Mailir	ng Address (Stree	t and Num	ber or Rura	al Route Numbe	er, City o	r Town, St	tate, Zip C	Code)	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of	Funeral Service	ic se	e			2. Name and Add 8900 REI		cility (SOL LEV	INSO	N &	BROS	, INC	08
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X	ath ce attend for us	ian	23b. Was decede in the past 1	12 months?		1 Live Birth 2	Fetal de		Ectopic pregna Other (specify)	ncy			1	Mo	te of deliv nth		Year
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0	hat the ed by detain	y P	Part II. Other sig	nificant condit	ons co	ntributing to death bu	t not resultin	ıg in the ı	underlying cause	given in Pa	art 1.	23e. Did	tobacco	use contr	ribute to t	ne cause of d	leath?
Ś.	uires t n sign ild be	g p	Cenzest	re Heer	feilu	1, Coroney	aring d	Here	, Chro	- Kid	Net	1 🗆	Yes 2	2 🗌 No	3 🗌 Pro	bably 4 🗆	Unknown
ord	w requ	olet	disean.	Stra 4		•						24a. Was	an opsv	24b. \	Were auto	psy findings impletion of c	available cause of
ဒ္ဓင	he lav te hav age 2	E O		-0-									ormed?	/	death?	·	
a	ian; T rtifica xtor, p	Bec	25. Was case ref examiner?	erred to medica							Death (Chec	k only one)					
=	hysic nis ce I direc	은	1 🗆 Yes						nt 3 L DOA		Nursing H	ome 5 🗆 Res	_)	
ō	ing P	ate:	27. Manner of De 1 ☑ Natural	eath 5 🗌 Pend	ing	28a. Date of injur (Month, Day,		o. Time o injury	W	ork?	п	28d, Describe	how inju	ary occurre	ed		
ion	ttendi death tor: A the fi	iĝ.	2 Accider 3 Suicide		igation Inot be	28e. Place of Injur	n/ At home	farm et		Yes 2	□ No	28f. Location	(Street a	and Number	er or Rura	l Boute Numi	her
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certificate:	4 🗌 Homicio	de deter	nined	building, etc.		, iairii, Su	reet, factory, offic			City or To			er or ribra	THOUSE TRUITS	001,
Ω	spital nours neral	ical	29a. Certifier	1 Certifyin	g Phys	ician: To the best of r	ny knowledg	e, death	occured at the ti	ne, date a	nd place, a	nd due to the c	ause(s) a	and mann	er as state	ed.	
	n 24 h	Medical	(Check only one)	2 Medical	Evamir	ner: On the basis of ex e Practioner : To the b	amination and	d/or inves	stigation, in my or	inion, deat	h occurred a	at the time, date	and place	ce, and due	e to the ca	iuse(s) and ma	anner state
	To the complete of the complet		29b. Signature a	nd title of certific						nse numbe			29d. D	ate signe	d (Month,	Day, Year)	
			I gal	i felfen		10				2 00	0		AL	ywr	29	2010	
	Óν	-	30. Name and a			ompleted cause of de	eath (Item 23a	a) (Type,	Print)		0	1 1		9111		hn	2.0
			31. Date filed (M) N	D Sinalit	r'e Signatura	of K	satt. mar,	2461	W. Br	mier 6	ive,	Dadin	~~	7 41	617
	Sta Registr			0 1 201	0	A Registra	J. A	ark	Saltimor,								

Carolyn Lynn Tellir			10 2746
	1- For State Certificate of Death	Reg. No.	
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)	Date of Death Month Day Year	3. Time of Death 1530 hrs
INEGICAI EXAIIIIIe	Carolyn Lynn Tellington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	August 19, 2010 h 4c. County of	
	1826 West Baltimore Street Baltimore	14c. County of	Deam
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth(MM/DD/YYYY)	Birthplace (State or
Director	218-90-4032 1 M 2 K F 47 Yrs, Months Days Hours Mir	— ` ` 1.	Foreign Country) MD
	Usual Residence of Decedent	01,03,1300	Country) 2 - 2
ku a	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	MD Baltimore City		1 X Yes 2 No
the Maryland a or 28a-f sh	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	t Country?
the M ror 2 Dire	1826 West Baltimore Street 21223	US	SA
death with the Maryland or items 23a or 28a-f show must be notified at once.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		American Indian, Black,
er death	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		
s after rral", o ninec.1	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Black
hours natur Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		ness/Industry
36 in 72 han " fical	Elementary/Secondary (0-12) College (1-4 or 5+)	Car D	ealershi p
5-0036 led within 72 hour sygiene. other than "natu the Medical Exan Completed	12 4 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maiden Surname)	- arersiir p
215-0036 be filed within 7 minal Hygiene. risked other than rent, the Medical Be Comple	несі 1		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Clifton Tellington 19b. Mailing Address (Street and Number or	Rural Route Number, City or Town,	State, Zip Code)
MD d 2 sho lth and th 27 is	Dwayne Tellington SON 1826 West Baltimo	ro Ct Ralto I	MD 21212
Healt Healt	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - C	MD 21213 lity or Town, State
Baltimore, permit. Pages 1 an Department of He Important: If ite	Ardent Cremation 8/3	30/2010 Hanove	er Maryland
altir Nartune Sertune Sortan	4 Donation 5 Other Specify: 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Ph		
inji in per m	Gulf Melley 12431 East Olive	=	
Physician	23a. Part I. Bifter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest, shock, or heart	Approximate Interval
/Medical Examiner	Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease		Between Onset and Death
Examinei	or condition resulting in death) Due to (or as a consequence of):		
-	Sequentially list conditions, b.		
nine	if any, leading to immediate Due to (or as a consequence of):		
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
executed an and all - transi	d.		
be ex sician nurial	UNPENDED		
tox 68760, leath certificate be eatending physicia for use as the buriar/sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of de	
ox 68 eath certi	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ancy Month	Day Year
BO) re death the att red for	1 Yes 2 V No 9 Unknown 9 Unknown		
ires that the signed by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	ite to the cause of death?
F. P.C	Obesity	1 Yes 2 No 3	Probably 4 Unknown
Records, The law requirer freate has been sig			ere autopsy findings available or to completion of cause of
Recc The lav cate ha			ath? Yes 2 No
# # # # # @	25. Was case referred to medical 26.Place of Death (Check	<u> </u>	
f Vita Physicia or this ce ral direc	examiner? 1 Yes 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursir	ng Home 5 Residence 6	Other: Scene
Of ng Ph	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion trendi leath. tor: the f	1 V Natural 5 Pending 2 Accident Investigation 1 Yes 2 No		
ivisior or Attencather death Director: I in by the	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:	4 Homicide determined (Specify)		-
To the Hos within 24 h To the Fur completely	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a		
To the Ho within 24 To the Fu complete!	and manner stated.		
			(Month, Day, Year)
	Cielor Cattle Vell O.C.M.E.	August 19, 2	
	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	21201	
State		21201) i
Registrar	SEP 0 1 2010 Runa 1. parle		
DHMH 17 Rev 1/2001	OCME ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Thomas W		State of Maryland / Department Certificate			nd Mer	ntal Hy		•	201	Ω	271.61	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	-			12	2. Date of Dea	eg. No. th	201	$\stackrel{\circ}{\dashv}$	3. Time of Death	
Medical Exami	ner	John Thomas Wilson					Month August 25	Day 5, 201	O Year		1754 hrs	
		4a. Facility Name (if not institution, give street and number) 700 Drum Avenue	4t	c. City, Town, o		of Death			County of I			
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	上	If Under 1 Ye		ler 24Hrs.	8. Date of Bir				hplace (State or	
Director		- /1/1	Yrş.		ys Hour		07-29		1 -			
		247 – 33 – 7914 1 AM 2 F YUSUAI Residence of Decedent	110.	lL			<u> </u>				,	
v any		10a. State 10b. County 10c. City, Town or Loc	catio	n							10d. Inside City Limits	
land f shov	ō			oitol		hts					1 Yes 🗏 No	
Mary r 28a-	Director	10e. Street and Number		10f. Zip Code			1	0g. Citi:	zen of What	Cour	try?	
death with the Maryland or items 23a or 28a-f show must be notified at once,	_	700 Drum Avenue 11. Marital Status		207		-1-0 / 6	-:		44 D	.	Latin Black	
eath w items	unera	1 Never Married 2X X Married Armed Forces?		Decedent of H s, specify Cuba					White, €	etc. Z	an Indian, Black, African	
fter de l'', or	ഥ	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	\	Yes 2 N	lo specify.	:			Specify: At	me	cican	
nours a	ed by	1 during	dent's	s Usual Occup	ation (Give	kind of wo	ork done	16b. F	(ind of Busin	ness/li	ndustry National	
36 nn 72 h nam "n	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	-	l Care			۵)				Health	
-003 I withi ther of	mo	17. Father's Name (First, Middle, Last)	ıa.	L Cale			First, Middle, I			1		
215 re filed tal Hy ked of	Bec	Leroy Harris Wilson			1	enia		hav				
21. could b d Men d Men is eve	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mail		Address (Stre	eet and Nur	mber or Ru	ral Route Nun	nber, Ci	ity or Town,			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Grace Wilson-Wife 137		Shady								
ore, of Hez If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or	othe	r place)		i i	Date	1	Location - Ci	•	·	
time Fage Trant:	ļ	4 Donation 5 Other Specify: Kingst							_		ee, SC	
Ball permit Depart Impor		1. Signature of Funeral Service Licersea 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, M										
Physician	-	a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart April -										
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Head	d								Between Onset and Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):	_									
	١,	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	_							_		
	Ē	cause. Enter Underlying Cause (Disease or injury that initialed										
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60, ate be		IF FEMALE: 23c. If yes, outcome of pregnancy	_					230	d. Date of de	livery		
OX 6876C eath certificate attending phys	ä⊓	past 12 months?	Feta	I death 3	Ectopie	c pregnanc	су		Month		ay Year	
	ysici	1 Yes 2 No 9 Unknown g Unknown	Othe	r (Specify)								
O. B. nat the d ad by the etached	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e un	derlying cause	given in Pa	art I.	23e. Did to	bacco i	use contribu	te to t	he cause of death?	
ords, P.O. I v requires that the s been signed by the should be detache	d by						1 Yes	2 🗸	'No 3	Prob	ably 4 Unknown	
of Vital Records, ng Physician: The law requir Wher this certificate has been someral director, page 2 should I	Completed						24a. Was a autop				opsy findings available empletion of cause of	
tal Reco	E O						perfor	med? 2 No	o dea	th? Ye:	s 2 No	
certificector.	Bec	25. Was case referred to medical examiner?	_	26.Plac	ce of Death	(Check on	ly one)					
f Vir	2	Hospital: 1 Inpatient 2 ER/Outpatie 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of				Nursing			nce 6 🗸	Other:	Scene	
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Division tal or Attendir rs after death.	icati	2 Accident Investigation Aug 25, 2010 1740 hrs	reet,				8f. Location (S	Street a	nd Number o	or Rur	al Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ertifi	Suicide 6 Could not be determined (Specify) Residence		•			or Town, S 00 Drum Ave	tate)				
Hosp 24 ho Fune etely fi	S S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ										
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investiged and manner stated.	gatio			curred at t	he time, date					
	Σ	29b. Signature and title of certifier			se number						th, Day, Year)	
		MM Drasse (Mt		0.0	.M.E.			Aug	ust 26, 20	710		
		 Name find address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 	Pe	nn Street, I	Baltimore	e, MD 2	1201					
	ate	31 Date filed (Month Day Year)				,						
Regist	rar	SEP 0 1 2010 Cenows B. Jan	Ka									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vivian S. Wilkins August 2610 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Baltimore Baltimore N/A If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 DA 12/18/1928 Director 216-36-4149 81 Maryland Usual Residence of Decedent 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Co. 1 Yes 2 X No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4603 Brightwater Ct. Apt F 21117 .S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 years Retired RN State of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judge Wilson Marion Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Kevin Wilkins(son) 4603 Brightwater Apt.F, Owings Mills, MD21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge Cem. 4 ☐ Donation 5 ☐ Other (Specify) 08/31/10 Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence of): **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular accident, hypertension. 1 Tes 2 No 3 Probably 4 Unknown Congestive heart failure, diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number pleted cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me,g906,09/01/2010dhb Certificate of Death Reg. NG = State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mai Garesche Norris Dick Pitts Saulsbury West August 2010 3:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1055 West Joppa Road Baltimore County Towson 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-28-5067 1 □ M 2**X** F Months Days Hours Jan. 29, 1915 Director 95 Salisbury, MD. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1055 West Joppa Road 21204 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 № Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 02 Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Archibald Dick, II Jean Boyd Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mai Garesche Carter P.O. Box 35300 Sarasota, Florida 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland Aug. 24, 2010 Evans Funeral Chapel and Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Cair, Sr. Peneral & Cremation Center, P.A.

Peneral Alternatives Funeral & Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Subdi Torde Hallar me Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to or as a conse uence of CERTIFICATION APPROVED BY MEDICAL EXAMINER cause. Enter Underlying Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 2 E 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy perform prior to completion of cause of death? Yes 2X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🔀 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending Subject fell out of bed 08/2010 **Unknown**^M Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1055~W.~Joppa~Road~Towson,~Mddetermined Towson, Home To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 050592 no ·M 23,2610

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

noud

Calls

31. Date filed (Mor

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Baldunza

21097

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29^{Day} 2010 Year Physician/ Charles Witmer Pfahler August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1X M 2 🗆 F 178-24-1902 Pennsylvania Director 79 Heual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. <u>601 Brightwood Club Drive</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc ģ 1 Never Married 2 🙀 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service & Parts Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Pfahler မ Rov Witmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) 601 Brightwood Club Drive Lutherville, Maryland Joan R. Witmer / Wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State Hilltop Serv. Corp. 8/31/2010 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Euneral Service Licenses 6 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ west ! DUD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I funeral director, completed filled in by

မ

Certificate:

Medical

only one 29b. Signature

MON 31. Date filed (Month, Day, Year) **SEP 0 1 2010**

examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Other) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 🔀 critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TONSON MD

140, State Registrar

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2010 Smith Alofs August 15 3:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Olney Winter Growth Adult Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | March 15 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** New York 1 ☐ M 2 X F 79 074-24-0693 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a, State 7 le marked other then "neturel", or items 23a or 28e-f show treumetic event, the Madical Extrait er must be notified at 1 ☐ Yes 2 No Director 01ney Montgomery Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 17721 Lochness Circle 20832 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Ie marked other then College (1-4or 5+) Elementary/Secondary (0-12) Retail Clerk Trainer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fi Be Euberta D. Smith Hubert L. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health and ant: If item 27 le r 15A Brookside Heights, Wanaque, NJ Heidi A. Mullen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 8/16/10 Alexandria, Va. ° 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Muriel H. Barber Funeral Home m-00470 P. O. Box 5038, Laytonsville, Md. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician Advanced dementia /Medical Due to (or as a consequence of) Examiner Alzheimer's disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician as the t IF FEMALE esn 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month jo in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Poorly controlled diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Failure to thrive page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, director Be Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 😿 No this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury 1 🗹 Natural 5 Pending within 24 hours atter uses...

To the Funerel Director: After the function of 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier no August 16, 2010 D 0028479 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Ave., Kensington, Md. 20895 Uma Prasad, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Sacked State AUG 17 Rasera Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2010 Orla Mae Adney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata Conter If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 F 80 Yrs Director 504-24-9151 South Dakota June 16, 1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Walten Eva. That is the ratified and once. 10b. County 1 □ Yes 2 🙀 No Director Maryland | Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Adolf Trudaeau Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 70 Village Street #312 Waldorf, Maryland 20602 Eugene H. Adney/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 8-20-2010 Charlotte Hall, Maryland 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01458 211 St. Mary's Ave. La Plata, Maryland 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or contribications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner iany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ∏Yes 2 ∏No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed3 page, certificate 1 ☐ Yes 2 ☐ No 2 No Division of Vital 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1🗗 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Mereokelli 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00056949 18 8 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 AFFAKS (H) BALG XD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 20 2010

· LAPLATA ; KD-

CRAIN HWY , STEIDS

32. Registrar's Signature

Dressed 1

Amend Item 21 per FH G907 9/1/10 dk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Connie Jean Augustine State of Maryland / Department of Health and Mental Hygiene Certificate of Death G907 9/10/10 dk Reg. No. 1-For StateAmend Item 1 per DVR Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 2350 hrs GONSTANCE JEAN AUGUSTINE CONNIE JEAN AUGUSTINE Medical Examiner August 13, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett Highway at Devil's Half Acre Road Accident Garrett If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 212-74-8214 45 June 4, 1965 Country) MD 1 M 2X F Usual Residence of Deceden 10d. Inside City Limits 10a. State Oc. City, Town or Location 10b. County 1 Yes 2 X No items 23a or 28a-f show Somerset Addison PA Examiner must be notified at once, Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 15411 **USA** 7706 National Pike Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Oecedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 5 Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. 3 X Widowed f Yes. Give Year Yes 2x No specify: White Oivorced Specify: "natural" ≥ Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than " traumatic event, the Medical Mental Hygiene. marked other than **Baltimore, MD 21215-0036** 12 Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Beitzel Margaret Miller Beitzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Redwood Dr., Apt. 180, Santec, CA 92071 Ashley Augustine--Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State ment (Capital Funeral Serv. 8/19/10 Baltimore MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, PA Alan M. Sowers per DVR 60 W Main Street, Frostburg MD 21532 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Oue to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit the Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical AMENOED UNPENDED ending physician use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown signed by the be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ó ₫ Records, P. 1 Yes 2 ✔ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? 1 🗸 Yes ✓ Yes 2 No 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ Hospital: 1 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this 1 Yes 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death 28c. Injury at Work? Certification: driver of auto in head-on collision with tractor FOUND: Natura! Yes 2 V No Pending 24 hours after death the Aug 13, 2010 trailer Director: 2345 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be .= Suicide or Town, State) Garrett Highway at Devil's Half Acre Roa, Accident, MD determined (Specify) Major Road / Highway Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ŧ one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 15, 2010 who completed cause of death (Item 23a) 30. Name and address of person Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD 31. Date filed (Month, ISEP Registrar's Signature State 01

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of Health and Mental Hygiene 0 2747 Certificate of Death Reg. No. 0 2747
	Physici	an	1. Decedent's Name (First, Middle, Last) David Bruce Betts, Sr. 2. Date of Death Month August 17, 2010 15:25p M
d	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examin	er	116 S. Tartan Dr. Elkton Cecil
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Months Days Hours Min. 4 UG 22, 1955 Pelaware
	D		Usual Residence of Decedent
	Manylar f show led at	Į.	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
	a with the	I Director	10e Street and Number 116 S. Tartan Dr. 10f. Zip Code 21921 10g. Citizen of What Country? United States
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinational De notified at ADES.	/ Funeral	11. Marital Slatus 12. Was Decedent Ever in U.S. Armed Forces? 1 Secretly Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: 1 Yes
-003	hours tural',	ed by	3 Widowed 4 Divorced Year or Dates: White
21215-0036	hin 72 s. sn *na	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)
21	ed with	Com	9 Owner Automotive
Maryland	ntal H ed oth	36	17. Father's Name (First, Middle, Last) William W. Betts, Sr. 18. Mother's Name (First, Middle, Meiden Sumame) Irene Starobynski
aryl	shouk ind Me i mark umatik	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 ealth a n 27 ls		Beverly Betts/Wife 116 S. Tartan Dr., Elkton, MD 21921
Baltimore,	ages 1 nt of H :: If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State
altin	mit. Paratmentoriani	1	'4 Donation 5 Other (Specify) St. Georges Cemetery 22, 2010 St. Georges, DE 21. Signature of Funeral Service Licensee
ñ	permi Depar Impor any ir		Hicks Home for Funerals, P.A. MD 21921
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **RELING OF ANTICLES** Approximate Interval Between Onset and Death 12/20/6.
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):
	₽ ∺	ner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury
_	cate be executed obysician and the burial-transit	xami	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
8760,	e be ex rsician e buria	caiE	d.
9	rtificat ng phy e as the	Medi	IF FEMALE:
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai Examin	23b. Was decedent pregnant in the past 12 roonths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month Day Year
	quires that in signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Test 2 Test 2 Test 3 Test Probably 4 Test 2 Test 3 Test Probably 4 Test Prob
of Vital Records,	The law requir ate has been si page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1
/ital		Be	25. Was case referred to medical examiner?
of \	di S	2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of eath (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Work?
ion	Attending ir death. ector: After by the fune	ation	27. Manner of eath 28a. Date of Injury 28b. Time of School Injury 28b. Time of School Injury 28c. Injury at School Injury at School Injury 28d. Describe how injury occurred Work? 1
Division	al or Atte after des Directo d in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the complete	Me	29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug 18, 2010
			296. Signature and title of certifier NUMMEN (M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dan Lahen, MD John Holking Hospital 1650 Orleans of Balf, MD212.
e.	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 9 2010 AUG 1 9 2010 AUG 1 9 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1-21 AM Medical YC 4a. Facility Name (if not institution, give street and nu Examiner 4b. City, Town, or Location of Death 4c. County of Death Elternhaus, Howard Davton 7. Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months (Month, Day, Year) an 14, 1917 North Carolina Director Jan 93 Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9706 Bellevue Drive 20814 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ Abasolum Carswell Carrie Mav Suttles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethesda, Maryland 20814 Edna Proestel/sister 9706 Bellevue Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 8/19/2010 4 Donation 5 Other (Specify) Woodbine, Maryland Sign : e of Funeral Service Licen Coing Homes Cremation Service P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 manue 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed ESCI 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 100 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? No No ျှ 1 🗌 Yes Other: within 24 hours after deaun.

To the Funeral Director. After this of a property of the funeral direction of the funeral direction. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 M Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and le of certifier 29d. Date signed (Month, Day,

State Registrar 31. Date filed (Month

10

THICU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Butler Month :30 AM Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Prince Fort Washing George If Under 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Hours Min. Month Day, Year 923 Maryland Director 87 218-14-3523 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Cheltenham Maryland Prince George 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 11904 Cross Trail 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lena Bush Brown Michael Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Murphy/Daughter 11904 Cross Trail Rd, Cheltenham MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 8/23/2010 Clinton MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility M01589 Adams Funeral 20608 Home Pa, Aquasco MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to for Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed eral Director: After this certificate if filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To I 1 🗌 Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BerWA 141) Branc AXMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 18 Backs Registrar But Baran

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2157 Madeline Brooks 2010 Medical UPUST 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Aguas Saint Hospital Balhmore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours Month, Day, April 26. Country) Director 218-28-4041 81 Usual Residence of Deceden or 28a-f shov 10a. State other traur atic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21202 USA 633 North Aisquith Street Apt. 7K 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 sho. ld te filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is named other than "na any injury or other traun atto event, the Medic once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Never Worked** N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosena Kilgore Fillmore Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12335 Rousby Hall Road, Lusby, MD 20657 Angela Bishop - sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State st. John UM Church August 14, 2010 | Lusby, MD 4 ☐ Conation 5 ☐ Other (Specify) Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dlade 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ Menosclanon disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autonsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 | No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D0068107 2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew Ballimore 900 Frenue 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ponald Physician/ 2010 10:30pm м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4857 Mariners Ct. Galesville Anne Arundel Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 12/9/1929 **1X**XM 2 □ F Months Days Hours Min. Country Director 483-26-3665 80 Iowa Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Tes 2XXNo MD Anne Arundel Galesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4857 Mariners Ct 20765 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

TAXYes 2 No 1948
If Yes, Give Black, White, etc "natural", or þ 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Teacher PG County other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Martyn Buchanan Mary Louise Crowl permit. Page 1 and 2 should Department of Health and M Important: If item 27 is ma any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Diana Buchanan</u> Mariners Ct. Galesville, MD 20765 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/17/2010 Glen Burnie, MD Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 77 Annapolis, Md 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Lanoma Physician/ COM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year 4 Pregnant 9 Unknown Pregnant at time of death 2 🗌 No sbeen signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 40 1 Yes Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2,2 No Hospital Other: 2| 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending nours after death. neral Director: Aft ifilled in by the fur 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated сотретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Beitzete Rd Sute 300 Amapalo 240

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

AUG 172010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 16 2010 07:00 AM August Delida Rose Cropper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 1178 Irishtown Road North East 8. Date of Birth (Month, Day, Year) March 27,1929 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 X F Kentucky Director 213-28-2140 81 March Usual Residence of Decedent works 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified 28a-f 1 Ves 2 No North East Maryland Ceci1 10g. Citizen of What Country? ò Funeral 21901 United States 1178 Irishtown Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after annet of Health and Mental Hygiene.
The file and "Annal Hygiene", or any file and "natural", or any file and "staumaitic event, the Medical Examil ury or other traumaitic event, the Medical Examil. 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify. 3 XVidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Gilbert David Grant Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Falini / Daughter P.O. Box 18, North East, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 21, Department of H Important: If ite any injury or ot once. North East on other olace Methodist Cemetery 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Other (Specify) 2010 North East, Maryland 21. Signature of Conseal Serv 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (of as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yes

9 Unknown Month Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfor 1 Yes I or Attending Physician: I after death.

Director: After this certifications 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending work? 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier ceeks 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CARMEN ALESANDRA CODDINGTON 15^{Day} AUG 2010 2:08 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20234 YANKEE HARBOR PLACE MONTGOMERY MONTGOMERY VILLAGE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 W Months Hours 0472072006 4 GUATEMALA Director 218-77-9627 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY MONTGOMERY VILLAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20234 YANKEE HARBOR PLACE 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?/
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ģ 1 ☑ Yes 2 ☐ No Specify: MAYAN If Yes, Give Year or Dates Specify: HISPANIC 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/AN/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID JAY CODDINGTON LANA LOVETTA INGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20234 YANKEE HARBOR PL., MONTGOMERY VILLAGE LANA CODDINGTON / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State GLENWOOD CEMETERY 08/24/201 ONEONTA, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ TAY SACHS DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC LUNG DISEASE years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical nding properties as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à SEIZURE DISORDER 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical

Box 68760 P.O. Records, Hospital or Attending Physician: The law requires Division of Vital within 24 hours after death.

To the Funeral Director: After completed filled in by the fu

Baltimore, Maryland 21215-0036

29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) D0062944 08/16/2010 Arrel Obelman, m.o. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19501 DOCTORS DR., GERMANTOWN, MD 20874 ARIEL DUBELMAN, MD

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

32. Registrar's Signature

1. 36Ach

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Carol Corwin August 18, 2010 5:25 A M Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Montgomery Rockville Date (Month, Da) Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Min. Months Hours Director 272-26-7471 80 Dec Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4708 North Chelsea Lane 20814 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Completed Specify: 3 X Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Retail/ Elementary/Seconday (0-12) Clerical County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Evans Dubbs Jewel . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Julie Corwin/daughter 4708 North Chelsea Lane Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 8/19/2010 Woodbine, Maryland Signature of Funeral Service Licenses Going Homes Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) General Debility Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir and -transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🄀 No
9 ☐ Unknown Pregnant at time of death Month Year ed by the a detached f 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 X Unknown should k 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \nwarrow Other (Specify) Hospice 2 X No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours af To the Funeral Discompleted filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · Kouerro D63748 August 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 7/2009

State Registrar J. Kouatchou,

M.D.

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

6001 Muncaster Mill Road Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27479 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Ċe	ertificate	of Death		R	eg. No.		
	Physician/ 1. Decedent's Name (First, Middle,Last)					2. Date of Dea	th	Year	3. Time of Death		
Medical Exami	ner	Jacqueline				Coligny		Month August 22			0000 hrs
		4a. Facility Name (if not institution 711 Camden Avenue)		umber)		4b. City, Town, o	r Location of Dea	th		ounty of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday		ar If Under 24H	rs 8 Date of Bir			thplace (State or
Director						Months Day		in.		Foreig	n New York
		131-38-6311 Usual Residence of Decedent	1 M 2 X F	63	3	Yrs.		4-21-	194/		
any		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
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Varyland 28a-f show any 1 at once.	Director	10e. Street and Number	<u> </u>		Dalio	10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
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ms 23	uneral	11. Marital Status	12. Was De	cedent Ever in l	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (- 14.		can Indian, Black,
or ite	Fu		1 Yes	2 X No				to Rican, etc.)		vvriite, etc.	
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hour natu	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		dent's Usual Occupa g most of working life			16b. Kind	of Business/I	ndustry
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be (Edward		(Colign	v	Irene			Sch	ening
21 nould d Mei is mai	ို	19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	iling Address (Stre	et and Number o	Rural Route Num	ber, City o	r Town, State,	Zip Code)
MD id 2 sho lth and n 27 is		Ray Schreiber	- Son		414	4 Stockya:	rd Road,	Eden, M	aryla	nd 218	22
ore, s l ar of Hea		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr			position (Name of ce r other place)	emetery,	Date	20c. Loca	ation - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S			emato	ry of Del	narva 8	-27-2010	De	lmar,	Delaware
Salt ermit. epartu nport		21. Signature of Funeral Service	Licensee) .	2	Name and Addres	e of Eacility	Bounds F			
	_	23a. Part I. Enter the disease, or	ellestact	Cu	Do not out	705 E. Ma	in Stree	t, Salis	bury,	Mary1	and 21804
Physician /Medical		failure. List only one cause	on eadh line.						est, snock,	or neart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		scloert a consequence		rdiovascu	lar dise	ase			Death
	1		b.	a consequence (JI).						
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	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence	วกิ:						-
uted nd ransit		events resulting in death) Last	d.		,						
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760, icate be ex physician the burial	Me	IF FEMALE:	23c. If yes,	outcome of pre	gnancy				23d. Da	ate of delivery	
		23b. Was decedent pregnant in the past 12 months?	Liver	oirth nant at time of d	2		Ectopic pregr	nancy	Mor	nth D	ay Year
Box 68's death certiff the attending of for use as	Physician	1 Yes 2 No 9 Uni	known 9 Unkn		eath 5	Other (Specify)			Î		
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Division tal or Attendir ss after death. al Director: A	iji			e of Injury - At h	ome, farm, s	treet, factory, office t	ouilding, etc.	28f. Location (S or Town, St		lumber or Rur	al Route Number, City
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To the within 2 To the complet	Medi		and manner s	tated.	and/or invest			at the time, date a			
		29b. Signature and title of certifie	1//26	7/ ///	7051	29c. Licens O.C.				signed (Mon 23, 2010	ш, µау, теаг)
		Valor SI	all 5	leek-	00.1	0.0.	·**		August	20, 2010	
		30. Name and address of person Victor Weedn MD JD	Assistant Me		ner 11	Penn Street, E	Baltimore. MF	21201			
St	ate	31. Date filed (Month, Day, Year)		egistrar's Signat	Ae Z	West, E					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 16. Year 0de11 2010 Chappel1 18:32 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 579 32 OCT 18. 1918 5492 91 Director Portsmith, Va Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Funeral Director Maryland Prince George's Camp Springs 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with to and Mental Hygiene.
is marked other than "natural", or items 23a or 6704 Coolridge Road 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George T. Smith Susie Odell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra Eaton (Daughter) 6704 Coolridge Road, Camp Springs, MD 20748 injury or other 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Uepartment of H Important; If ite 20c. Location - City or Town, State Date Aug 25, 2010 4 ☐ Donation 5 ☐ Other (Specify) Olive Branch Cemetery Portsmith, Va 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory liture. List only one cause on each line. shock Immediat ause of disease o condi n resulting in death Physician/ Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate insequence of cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Pregnant at time of death ed by the a detached f 1 Yes 2 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' performed? Yes 2 No this certificate 2 🗌 No 1 🗌 Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 M No Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 V Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

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State

29b. Signature and litle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Alba 0. Ciminesi 14,2010 2005 M August /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Rehabilitation & Nursing Ctr. Salisbur Wicomico 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/08/1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 M 2 X F Days 156-16-2169 85 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or items 23a or 28a-f show 1 XYes 2 No Director Ewing Mercer Jersey 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 08628 USA 451 Silvia Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ratment of Health and Mental ruygene. Joriant: If Hem 27 is marked other than "natural", or Injury or other traumatic event, Its. Muchan Expiri 1 ☐ Yes 2 🗷 No Specify: Specify: white ⋧ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) clerical worker state government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Modestini Fannie George ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) Linda Kellogg/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 214, Tylerton, MD 21866 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (SpeciEntombment 8/20/2010 Mary's Cemetery Hamilton, NJ permit.
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an inju Signature of Funeral Service Licensee Holloway Funeral Home Professional Association David 501 Snow Hill Rd., Salisbury, MD 21804 C LOCCO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 Physician 4 can disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 II Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Watural 5 Pending in 24 hours after death.

Be Funeral Director: A lettely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifler 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar H.

Dilliam

31. Date filed (Month, Day, Year)

200

M.D. ≪(

Jeanne Fisher Callahan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	State of Maryland	/ Department of He	ealth and Mental Hygier	ne

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	Registrar Certificate of Death Reg. No.										
Physician/ Medical Examiner		Callahan						. Date of Death Month August 13,	Day Year		Time of Death 1515 hrs
	4a. Facility Name (if not institution US Rt 50, B, at US F	· ·			City, Town, o Salisbury	or Location	of Death		4c. County o		
Funeral Director	5. Social Security Number 090-18-9460		Mooths Days Hours							Foreign	ace (State or Maryland
nd show any cc.	Usual Residence of Decedent 10a. State 10b. County Maryland Wic	comico	Salisk		,					10	od. Inside City Limits Yes 2 X No
the Maryland a or 28a-f show any tified at once, Director	10e. Street and Number 1715 Old Mil	ll Lane			10f. Zip Code 218	801		10	g. Citizen of Wha	at Country	?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 X Widowed 4 Div	arried 12. Was Decedent Eve Armed Forces? 1 Yes 2 X orced If Yes, Give Year or Dates:	No	If Yes	, specify Cuba	an, Mexican	, Puerto Ri		White,	etc. white	
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by F	Elementary/Secondary (0-12)	College (1-4 or 5+)	d		Usual Occupation of working lift				16b. Kind of Bus		stry
1215-0(I be filed wi ental Hygien riked other vent, the M Be Cor	17. Father's Name (First, Middle William H. F	isher				Je	ennie	Mae	aiden Surname) Howser		
MD 21 d 2 should lth and Me n 27 is ma umatic ev	19a. Informant's Name/Relations David Gillmor			4 H	arding	St.,			er, City or Town		Code)
imore, Pages 1 an ment of Hea tant: If iter	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other S	cremato	Place of Disposition (Name of cemetery, crematory or other place) odlawn Cemetery 8/				Date 20c. Location - City or /18/2010 Easton, M			vn, State	
Balti permit. Departn Importi	21. Signature of Funeral Service		,	和 创 501	Poway ^{re} l Snow I	Fulfer's Hill E	al Hor Rd., S	me Prof Salisbu	essiona ry, MD	l Ass 21804	sociation
Physician /Medical Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.	death. Do not	enter the	mode of dying	g, such as c	ardiac or re	espiratory arres	st, shock, or hear		pproximate Interval Between Onset and Death
	or condition resulting in death) Sequentially list conditions,	Due to (or as a conseque	,								
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque									
760, ficate be executed g physician and s the burial - transit	UNPENDED	d								-	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown							elivery Day	Year		
ires that the signed by the detache	Part II. Other significant condit	ions contributing to death but	not resulting	in the und	erlying cause	given in Pa	nrt I.		acco use contrib		cause of death?
of Vital Records, P.O. ag Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detactor. To Be Completed by F.							-	24a. Was ar autopsy perform 1 ✓ Yes 2	pri ned? de		y findings available pletion of cause of
Vital Recysician: The his certificate director, page	25. Was case referred to medica examiner?				26.Plac	e of Death		y one)			
F Vit	1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3	DOA	Other ₄	Nursing H	lome 5 R	esidence 6 🗸	Other: Sce	ene
Division of ' Division of ' pital or Attending Ph ours after death. filled in by the funeral Certification: T	27. Manner of Death 1 Natural 5 Penc 2 Accident Invest	28a. Date of Injury (Month, Day Year) Aug 13, 2010 stigation	28b. Ti 0000 I	me of Injui hrs		ury at Work Yes 2 ✔	Pa		w injury occurred an auto to a		sion
Division o spital or Attending lours after death. neral Direct death. filled in by the fune Certification:	3 Suicide 6 Coul 4 Homicide	d not be mined (Specify) Major I			actory, office I	building, et	c. 28i	f. Location (Str or Town, Sta Rt 50, B, at	reet and Number ite) t US Rt 13, Sal	or Rural R isbury , M	Route Number, City
4 Homicide determined (Specify) Major Road / Highway US Rt 50, B, at US Rt 13, Salisbury, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day)											
Ž	29b. Signature and title of certified	sell mix			29c. Licens O.C.				29d. Date signed August 14, 2		Day, Year)
En	30. Name and address of person Pameta E. Southall, M		. ,	111 F	Penn Stree	et, Baltim	ore, MD	21201			
State Registrar	31. Date filed (Month, Day, Year)	32. Jegistrar's Si		day					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not-institution, give street and number **Examiner** elaware If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 10 M 2□ F Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene.

If an 21 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, Ite Micinal Examinar must be notified at 1 ☑ Yes 2 ☐ No 10, Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 9805 Funeral 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DING 8 17. Father's Name (First, Middle_Last) Be ပ 19b. Mailing Address (Street and Number or Rugal Route Number, City or Town, State, 19a Informant's Name/ elationship (Type, 20b. Place of Disposition (Name of cometery, crematery) or other place Date 20c. Lot tion City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fuyeral Service Licensee 22. Name and Address of Pacility tuneral Home Wilmington Part1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancor inknaon Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation To the nous after death.

To the Funeral Director: Aft М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tite of certifier 29c. License number 8.17.2010. 00023322 Igeholow 8 MD

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 9 2010

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.S Jackden MD

126 A, E High ST, Ed 32. Registrar's Signature Annua S. Santh

Elken MD 21921.

DHMH 17 Rev 7/2009

Registrar

68760

Box

P.O.

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 🗆 No

Reg. No.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Yes 2□No

1:05aM

Year

9. Birthplace Country)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

GUGUST 17,2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

sbury Ratteratts : 118 MD 20781 A-D DRE Mu 4230 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

BBM

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27486 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Katherine August 10:25 aM Darmstead Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Calvert Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year
Nov 11, 1920) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XXF 579 07 9113 Washington DC 89 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland 1 Yes 2xX No Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8840 Stratford Court 20736 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√XNo Specify Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry A. Schaefer Katherine D. Culloty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael H. Darmstead (Son) 10515 Brandywine Road, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 Other (Specify) Aug 20, 2010 Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature Funeral Service Line & Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Cardio voscular direase Physician/ Atheroscierotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). of any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕶 No Day Month Year Pregnant at time of death 9 Unknown g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pancreatic Tumer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementio has autopsy performed after death.

Director: After this certificate 1 Yes 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o within 24 hours af To the Funeral Di completed filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 GYAN C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Deale Road

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August ¹4, Guy Elliott Dwier 2 6 10 9:59 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Texas 1 🕅 M 2 □ F (Month, Pay, Year) 8/7/1957 53 231-86-5553 **Director** Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert 1 X Yes 2 ☐ No Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 350 Wilson Road 20639 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Swimming Pool Builder Pool Company injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Harold Thomas Dwier Betty Lou Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f and 2 sl f Health a item 27 i Pamela Dwier/Wife 350 Wilson Rd., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Chesapeake Crem. 4 Donation 5 Other (Specify) 8/21/10 Beltsville, MD 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service Licensee 010 Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacy line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical attending IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending thours after death.

uneral Director: After the function of th ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed within 2 To the I 3 - Sentifying Nu the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertific 29d. Date signed (Monjh, Day, Year)

State Registrar

den

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

31. Date filed (Month, Day

se of death (Item 23a) (Type, Print)

Signature

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State Registrar

KRYSTAL THOMAS, CRNP 31. Date filed (Month, Day, Year) AUG 16 2010

29b. Signature and title of certifier



- Show CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

RO77623

29d. Date signed (Month, Day, Year)

8-11-10

10-06068 Santiago Fidel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 27489 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3 Time of Death Month Santiago Fidel Jr. Month Day August 13, 2010 Medical Examiner 1046 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Domenican **Funeral** Months Hours Director 45 110-80-2329 1 M 2 F 03/03/1965 Count Republic Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 X No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4771 Cardinal Drive 21804 USA Ö ල 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 1 Yes 1 X Yes 2 No specify: Dominican 3 Widowed 4 Divorced If Yes, Give Year Specify: Dominican 15. Decedent's Education (Specify only highest grade completed) within 72 hours 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it. Pages I and 2 should be filed within them to Health and Mental Hygiene. San: If them 27 is marked other them or other traumaric. 5-0036 owner/operator shoe repair 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Santiago Fidel Sr. Antonia Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Virginia Fidel/spouse 4771 Cardinal Dr., Salisbury, MD 21804 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Baltimo permit. Page Department o Salisbury Crematory 8/17/2010 4 Donation 5 Other Specify. Salisbury, MD Signature of Funeral Service Licensee 22 Har Toways Fineral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ₩. -accolousan Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Retween Onset and failure. List only one cause on each line /Medica a. Aortic Dissection Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year 2 Pregnant at time of death Other (Specify) isigned by the atte 1 Yes 2 No 9 Unknown 9 Unknown <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è diabetes mellitus 1 Yes 2 No 3 Probably 4 V Unknown Completed ificate has been si of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed</u> death? certificate ✓ Yes 2 1 🗸 Yes No director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes 2 ို No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Division 5 Pending 1 Yes 2 No death. the | Director: 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide Could not be or Town, State) within 24 hours a To the Funeral determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2010 ramah 9 30. Name and ad resis of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State Lensura Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Μ DOLORES UGUST LORRAINE GROSSNICKLE 2010 12:56P Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Dct 29 Months Min. Maryland 213-24-9638 82 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Frederick Frederick ٥ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6128 Quinn Orchard Road 21704 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates Specify: White Completed 3 ₺ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot George Edward Crouse, Sr. Fanny Victoria Shafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3024 Glenvue Drive, Westminster, MD 211.57 Sylvia Boone / Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or Mt. 8/17/2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Byteral Service Li ROBERTANE Address of Taging & SON FUNERAL HOMES, P.A. 201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complication shock, or healt failure. List only one caus the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ CORONAR ATTERS disease or condition resulting in death) DISCASE Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial Physician/Medical nding p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached fi P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Onknown Completed Hy pertension 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA ပ္ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural Natural
Accident
Suicid 5 \square Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8/13/2010 D39444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredon L. WO. 21702 muns JOHNSON Dane

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Box 68760

of Vital

Division

32. Registrar's Signature

CEMMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	e of Maryland / Dep Co	partment of F ertificate of I		, ,		0 27491
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medi		BRIDGET C. HAHN	August		010 818 AM			
	Examir	ner	4a. Facility Name (If not institution, give street and Memorial Hospit	tal	4b. City, Town, or Easto	п		4c. County of	Talbot
В	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs. last birthda 58 Yrs.	Months Days	If Under 24 Hrs Hours Min.		Year) 952	B. Birthplace (State or Foreign Country) IRELAND
	D O		Usual Residence of Decedent	10c. City. Town or	1 4:				10d. Inside City Limits
	f shov	ō	10a. State 10b. County	,,					1 ☐ Yes 2X No
	the N	rect	MD TALBOT 10e. Street and Number	EAST	10f. Zip Code		10	g. Citizen of Wh	at Country?
	3a or	Ö	55 PARK LANE		21601		UN	VITED ST	ATES
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinations to multiple at	by Funeral Director	1 Never Married 2 Married 1 Yes	d Forces? es 2 Man No Give	3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black,	- American Indian, White, etc. WHITE
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212	within jiene. r than "	dwo	Elementary/Secondary (0-12) Colleg	je (1-4or 5+)	ITRESS	"		FOOD SE	RVICE
	should be filed vand Mental Hygies marked other taumatic event, the	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M		
/lar	uld be Menta arked	To E	MARTIN MURPHY			MARGARI	ET O'CONNO	R	
Jar	2 sho h and risma rauma		19a. Informant's Name/Relationship (Type. Print)		iling Address (Street				tate, Zip Code)
e,	1 and Healti em 27 ther 1		CHARLES HAHN/HUSBAND 20a. Method of Disposition		PARK LANE,				ity or Town, State
mor	Pages ent of nt: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal fr	om State CHESAPEA	position (Name of rematory or other plac KE CREMATI	ON OS/2			ILLE, MD
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee	RCERS D	22. Name and Addres	ss of Facility	N & NEWNA	M FUNER	AL HOME, P.A.
8760,	Physician and physician and the burial-transit the	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Respirato		suffir	r crenc		Approximate Interval Between Onset and Death
P.O. Box 68	t the death certific by the attending p ached for use as	Physician/Med	in the past 12 months?		3 ☐ Ectopic pregnanc; 5 ☐ Other <i>(specify)</i> _	у		23d. Date Mont	1
	res tha signed be det		Part II. Other significant conditions contributing	o death but not resulting in the	underlying cause give	en in Part I.		S	ute to the cause of death?
Records,	e law requir has been s e 2 should	Completed by					1 ☐ Yes 24a. Was an autopsy	24b. We	ere autopsy findings available or to completion of cause of
	sician; The certificate h rector, page							26 No 1 □	ath? ☐Yes 2☐No
of Vital	Physician; r this certific ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 □ No Hospital:	☐ Inpatient 2 ★ ER/Outpat	iont 3 7 DOA Othe	or:	ath (Check only one		
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ion	Attending It death. ector; After by the fune	atio	2 Accident investigation	Month, Day, Year) Injury		Yes 2 □ No			
Division	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. P	ace of Injury - At home, farm, suilding, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, de ne basis of examination and/or	eath occurred at the tir investigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	luse(s) and man ite and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier Depis	ty Medicul Exu	29c. Licenson	e number 9 4 0 1 2	0 29	Augus	Month, Day, Year) 1 13, 2010 2140 1400/15, Marylon
	00 5		30. Name and address of person who completed of	cause of death (Item 23a) (Typ	e, Print)	00 M 1	1 141	11 Au.	21401
	CS 5	10	31, Date filed (Month, Day, Year)	2. Registrar's Signature	re centi	e 15/v	101 # 11	11 1700	imports inary wind
	Sta Registr	_	AUG 1 6 2010	Benown B.	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Physician/ MADELINE G. HALL AUG 15 5:00 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19915 FISHER AVE. MONTGOMERY POOLESVILLE Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) MD Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 PF Hours 03/15/1922 213-12-7637 88 Yrs. Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside, City Limits Director MD MONTGOMERY POOLESVILLE 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19915 FISHER AVE. 20837 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ AMOS A. WACHTER STELLA NANCY MOSER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 1 8 0 38397 MORRISONVILLE RD., LOVETTSVILLE, VA 19a. Informant's Name/Relationship (Type, Print) NANCY HOLMES / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MONOCACY CEMETERY 08/20/2010 BEALLSVILLE, 21. Signature of Funeral - rv ce Licenses 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL disease or condition resulting in death) INFIRCTION invite Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit HTHEROSCLEROSIS Cers that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atter page 2 should be detached for u in the past 12 months? Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HLZHEIMERS JISEASE 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIABE TES 24a. Was an autopsy HADEKLENSION 1 ☐ Yes 2 ☐ No 21 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year Hussin 86 2010

State

Registrar

10

DRIVE

FRENPRICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSAIN

32. Registrar's Signature

Book St. holy

A.

NAAZ

31. Date filed (Month, Day, Year)

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State of Man	yland / Departmen	t of Health a	and Mental Hygie	ne 💪

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Physicia Medical Exami			2. Date of De Month August 1	Day Year	3. Time of Death 0018 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	on of Death	4c. County of Death						
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any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	_	10e. Street and Number 10f. Zip Code 11803 OLD FORT ROAD 20744	i.	10g. Citizen of What Coun UNITED STATI						
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Baltimore, permit. Pages 1 ar Department of Hee Important. If ite		4 Donation 5 Other Specify: CEDAR HILL CEMETERY		O SUITLAND,	CONTRACTOR OF THE PARTY AND TH					
Bal permi Depar Impo injur	ļ	22 Junature of Funeral Service Line 22 Name and Address of Face THORNTON FUNE 3439 LIVINGSTO	ON ROAD, IND	IAN HEAD, MA	20640 ARYLAND					
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit		d. UNPENDED AMENDED								
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Division of Vital Records, ra or Attending Physician: The law requiring after death. The law for this certificate has been sized in by the funeral director, page 2 should the control of	ē	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wo	_	how injury occurred						
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Lospital Hours a uneral	- 1	4 Homicide (Specify) 29a. Certifier 1 Certifies Physician: To the best of my knowledge death segured at the time date and								
Divi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.								
128711	Ž	29b. Signature and title of certifier 29c, License number O.C.M.E.	er	29d. Date signed (Mont August 18, 2010	h, Day, Year)					
10	-	30. Name and address of person who completed cause of death (Item 23a)		, tagast 10, 2010						
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201							
St Regist	ate rar	31. Date filed (Month Cerves) 20 2010 Lenura A. Sacrel								

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Carlos Roq∪e Hacl	75	271.0
	Registrar Reg. No.	
Physician/ Medical Examine	Month Day Year	me of Death 727 hrs
And Car Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	27 1113
	13001 Jackson Drive Oxon Hill Prince George's	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace	e (State or
Director	Magtha I David Library Min	CHINC
	Usual Residence of Decedent	TON, DO
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the Maryland a or 28a-f show any tified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	ANITA R. LAMBERT / SISTER 13001 JACKSON DR., FT. WASHINGTON, MD	
re, 1 and f Heal f iten er tra	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State Crematory of CFE MCDATA AUGUST 20c. Location - City or Town, 1 X Burial 2 Cremation 3 Removal from State Crematory of CFE MCDATA AUGUST	State
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SOX death e atter for u	1 Yes 2 No 9 Unknown Unknown	
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To the Ho within 24 To the Fu Complete!	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of the certifier)	
	O.C.M.E. August 13, 2010	
SEM	30. Name and address of person who completed cause of death (Item 23a)	
1	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	a 31. Date filed (Month Par Year) 2010 32. Registrar's Signature	
Registra	AUG 19 2010 Server Signature.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mai	ryland .	/ Depa	rtment of F tificate of L	lealth and I Death	Mental Hy	giene, Reg. No.	2010	27495
			Decedent's Name (First, Middle, La	ist)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Dea			3. Time of Death
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	Funeral Director			Sex 7. Age (i 1 □ M 2 👺 F 8	in yrs. last b 1	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 08/03/	1929	Count	lace (State or Foreign ry) gton, DC
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	with t 23a Ist be	Funeral Director	13497 Marine Av	enue			20657		ł		ited Sta	,
	eath tems er mu	Fun	11. Marital Status	12. Was Decedent Eve	er in U.\$.	13. W	as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		4. Race - America	
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🗗 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🖾 No Specify:					Black, White, e	
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Maryland 21215-0036	e filec ntal H ed otl even	To Be	17. Father's Name (First, Middle, Last)	_				18. Mother's Nam	, -		,	
ž	should b and Mer is mark raumatic		John William Ja 19a. Informant's Name/Relationship (Eleanor			
	ひせなる		James Hood / Spo	,	- 1			Avenue,		-	r Town, State, Zip Code)	
ē,	1 and f Heal item 2		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		Date Date		cation - City or Tov	
E			1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			-	atory or other place n Crematory	9) 08/	14/2010		andria, Vii	·
Baitimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	see	4			s of Facility Ra	usch Fune	ral H	ome, P.A.	дина
ш	ಇಇ ಕ ಇ ಲ	3	Chickael Kevi	Hardiner.	<u> </u>			Lane, P.O.			, Maryland	20657
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that caused th one cause on each line.	death, Do	o not enter	the mode of dying	g, such as cardiac	or respiratory arr	est,	1	Approximate Interval Between
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20	phys the	ledical		d				-				
S	certifi inding use a	<u>\</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						2:	3d. Date of deliver	v
BOX 68	death	Physician/M	in the past 12 months?	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown			Other (specify)	/ 				Day Year
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			1 /2-1	W.D			D585	72			st 13, 2	
	1/1		30. Name and address of person who		h (Item 23a) (Type, Pri				ugu	20 10, 2	<u> </u>
łR	W 9		Gwyneth Anne Blattau, 31. Date filed (Month, Day, Year)					rince Fred	erick, Mar	ryland	20678	
	State Registra	-		32. Registra s	Signature	B.	parker					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROWE TUDIK Month 14, MARY 201^{vea} August 1:00PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Rehabilitation Ctr. Washington Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 M F Days Hours South Carolina 239-64-4323 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tx☐ Yes 2 ☐ No MD Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12301 Firth of Tae 20744 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give White 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Stokes J.W. Truesdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12301 Firth of Tae Ft. Washington, MD 20744 Ronald Rowe/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 8/19/2010 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Signature of Funeral Service Licenses Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ATHOROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 ☐ No g Unknown g \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be

law requires that the death certificate be executed Box 68760 Records, P.O. To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the tuneral director, page Division of Vital

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Funeral

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29a. Certifier

(Check only one)

Examiner

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within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

BBMI State

29b. Signature and title of sertifier PHYSICIAN

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 53787

ROAD

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 18th 2010 AUGUST

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SULESH VERGHESE 31. Date filed (Month, Day, Year)

32. Registra s Signature 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

LIVINGSTON

BUITE 101

2074

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ G1enn August 11 3:27 A.M Asa James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4085 Shoreham Beach Road Edgewater Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** May 5, 1947 1**X** M 2 □ F Months Days Hours 63 214-46-4470 Director Usual Residence of Decedent 10b. County 28a-f shov 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Anne Arundel 1 Yes 2 X No Edgewater 9 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4085 Shoreham Beach Road 21037 U.S.A items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 🌠 No If Yes, Give þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white "natural", Specify. Completed 3 Widowed 4 X Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working 2 should be filed within 72 h and Mental Hygiene. ? is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the charter boat captain charter boat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Glenn James Laura Evelyn White ge 1 and 2 should but of Health and Merit item 27 is mark. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Asa James, II, son 4085 Shoreham Beach Road, Edgewater, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hall Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Premoval from State 4 Donation 5 Other (Specify Metropolitan Crematory 08/11/2010 Alexandria. VA 22. Name and Address of Facility Rausch Funeral Home, P.A. of Funeral Service Licen 8325 Mt. Harmony Lane, Owings, MD ase, or compli<mark>d</mark>ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the dis Approximate Interval Between shock, or heart failu Immediate Cause Final disease or condition Onset and Death una Physician conce Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Ilrijury that initiated events resulting in death) Last executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Yes 2 No ed by the g Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autop perform certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 D Nursing Home \$ Residence 6 Other (Specify) this s after death.

I Director: After this of in by the funeral di 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natura 2 Accident Cuicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hours.
the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best on the best on the best on the best on the cause (s) and manner as stated. (Check within 2 only one 29b. Signature a 29d. Date signed (Month, Day, Year)

SEN

State

AUG 13 Registrar

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31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harvey Lee Meadows Jr. 2:40 PM August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 22 Charles Lane Cecil Warwick Social Security Number 6. Sex 1 X M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 02/24/1943 67 Yrs 222-26-5597 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f s notified MD Cecil Warwick 1 Yes 2 X No 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 21912 22 Charles Lane USA items ; death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates ō þ 1 Never Married 2 X Married 2 No 5-0036 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 ealth and Mental Hygiene. n 27 is marked other than er traumatic event, the Ms within 7 College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Line Worker -Security 12 Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Verna Mae Asberry þe Harvey Lee Meadows Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Carol Meadows / Daughter 107 North Hunter Forge Road, Newark, DE 19713 Department of Health Important: If item 27 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place United Crematory Services ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/19/2010 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) Signatil e Funeral Service Cen ^{22. Name and Address of Facility} Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 197 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Qo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Tex disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death ate has been signed by the a page 2 should be detached a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy After this certificate 1 ☐ Yes 2 No Yes 2 X 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowle 2f certifier 29b. Signature and title 29d. Date signed Name and address of person who completed cause of death (Item 23a) (Type, Print) 21/2 MO 31. Date filed (Month, Day, Year, 32. Fegistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2010 5:40 Рм Ellen McConnell Margaret Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital **Funeral** Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Wash. Director 217-42-0106 68 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MD Calvert <u>Huntingtown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 6011 Solomons Island Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Brent Florence Payne Josephine Wendorff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michael P. McConnell, spouse 6011 Solomons Island Road, Huntingtown, MD 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft Lincoln Cemetery 08-20-2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. llom 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DIABETES TYPE ${\mathbb T}$ Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ HYPER TENSION Division of Vital Records, cate has been sig page 2 should b Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE CHRONIC Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death?
1 Yes 2 No certificate director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 KER/Outpatient 3 IDOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 40370

Registrar

DHMH 17 Rev 7/2009

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32. Registra s Signature

Ste 310 Prince Frederick, UP 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WISHPUSIL

AUG

31. Date filed (Month, Day, Year)

104

68760

Box

P.O.

Records,

Division of Vital

State Registrar

11120 New Hamphire

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sean Saedi

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*305 Silver Spring, Maryland 20904